NOTE

This Microfiche meets the quality requirements of the American National Standard for Microfiche of Documents (ANSI PH5.9-1975). However, because of imperfections in the document from which it was made, it contains images that are illegible or difficult to read. The source document for this microfiche is the best copy that could be obtained prior to filming.

CIS

Congressional Information Service,
Washington, D.C.

STATUS OF THE MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

MARCH 1, 1988

Serial 100-57

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
88-248 WASHINGTON : 1988

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

H781-10

COMMITTEE ON WAYS AND MEANS

DAN ROSTENKOWSKI, Illinois, *Chairman*

SAM M. GIBBONS, Florida
J.J. PICKLE, Texas
CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ANDY JACOBS, Jr., Indiana
HAROLD FORD, Tennessee
ED JENKINS, Georgia
RICHARD A. GEPHARDT, Missouri
THOMAS J. DOWNEY, New York
FRANK J. GUARINI, New Jersey
MARTY RUSSO, Illinois
DON J. PEASE, Ohio
ROBERT T. MATSUI, California
BERYL ANTHONY, Jr., Arkansas
RONNIE G. FLIPPO, Alabama
BYRON L. DORGAN, North Dakota
BARBARA B. KENNELLY, Connecticut
BRIAN J. DONNELLY, Massachusetts
WILLIAM J. COYNE, Pennsylvania
MICHAEL A. ANDREWS, Texas
SANDER M. LEVIN, Michigan
JIM MOODY, Wisconsin

JOHN J. DUNCAN, Tennessee
BILL ARCHER, Texas
GUY VANDER JAGT, Michigan
PHILIP M. CRANE, Illinois
BILL FRENZEL, Minnesota
DICK SCHULZE, Pennsylvania
BILL GRADISON, Ohio
WILLIAM M. THOMAS, California
RAYMOND J. McGRATH, New York
HAL DAUB, Nebraska
JUDD GREGG, New Hampshire
HANK BROWN, Colorado
ROD CHANDLER, Washington

Robert J. Leonard, *Chief Counsel*
M. Kenneth Bowler, *Staff Director*
A.L. Singleton, *Minority Chief of Staff*

Subcommittee on Health

FORTNEY PETE STARK, California, *Chairman*

BRIAN J. DONNELLY, Massachusetts
WILLIAM J. COYNE, Pennsylvania
J.J. PICKLE, Texas
BERYL ANTHONY, Jr., Arkansas
SANDER M. LEVIN, Michigan
JIM MOODY, Wisconsin

BILL GRADISON, Ohio
HAL DAUB, Nebraska
JUDD GREGG, New Hampshire
ROD CHANDLER, Washington

CONTENTS

Page

Press release of Friday, February 12, 1988, announcing hearing 2

WITNESSES

Prospective Payment Assessment Commission, Stuart H. Altman, Ph.D., Chairman, and Don Young, M.D., Executive Director 5

U.S. General Accounting Office, Michael Zimmerman, Senior Associate Director, Human Resources Division, Thomas Dowdal, Group Director, and Terry Davis, Project Manager 30

American Hospital Association, Jack W. Owen 72

Anderson, Gerard F., Ph.D., Center for Hospital Finance and Management, the Johns Hopkins Medical Institutions 44

Rubin, Robert J., M.D., Health & Sciences Research Incorporated 50

SUBMISSIONS FOR THE RECORD

Alabama Hospital Association, Tommy R. McDougal, statement 90

American Medical Association, statement 96

American Society of Internal Medicine, statement 100

Federation of American Health Systems, Michael D. Bromberg, statement 110

Hasen, Sophia, Canton, OH, statement and attachments 114

Illinois Hospital Association, Sister Sheila Lyne, statement 133

Matsui, Hon. Robert T., Hon. Tony Coelho, Hon. Don Edwards, and Hon. Leon Panetta, all Representatives in Congress from the State of California, joint statement 135

Mercy Hospital and Medical Center, Chicago, IL, Sister Sheila Lyne, statement 133

National Committee To Preserve Social Security and Medicare, Hon. James Roosevelt, statement 137

STATUS OF THE MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM

TUESDAY, MARCH 1, 1988

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:35 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, FEBRUARY 12, 1988

PRESS RELEASE #19
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON THE STATUS OF THE MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM, TO BE HELD ON TUESDAY, MARCH 1, 1988

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on the status of the Medicare hospital prospective payment system and the report of the Prospective Payment Assessment Commission due on March 1, 1988. The hearing will be held on Tuesday, March 1, 1988, beginning at 9:30 a.m., in room 1100 Longworth House Office Building.

The hearing will include testimony from Stuart Altman, Ph.D., Chairman of the Prospective Payment Assessment Commission (ProPAC), the Congressional Budget Office, the General Accounting Office, and other expert witnesses.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for inclusion in the printed record of the hearing.

BACKGROUND

The prospective payment system (PPS) was adopted in 1983 as the method of hospital payment for Medicare. Hospitals are paid a prospectively determined amount per patient stay based upon diagnosis related groups (DRGs). The DRG payments are updated yearly based upon changes in the hospital market basket, an index of the prices of goods and services purchased by hospitals, and other factors, including, new technology, productivity, site-of-care, and coding of diagnostic information.

The Prospective Payment Assessment Commission was established in 1983 to advise Congress and the Secretary of Health and Human Services. The Commission is composed of 17 individuals knowledgeable in hospital financing and health economic issues. The Commission is required to report to the Secretary by March 1, 1988, on an appropriate update factor for hospital payments for fiscal year 1989.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, March 25, 1988, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

Chairman STARK. The Subcommittee on Health hearing will begin. Today, we will examine the status of the Medicare hospital prospective payment system and its impact on hospitals.

We are pleased once again to welcome Dr. Stuart Altman, Chairman of the Prospective Payment Assessment Commission. His expertise has proved helpful in the past, and I am sure will again be helpful to the subcommittee as we examine these payment issues.

In prior years, we have reviewed ProPAC's report; however, the recommendations regarding payment changes which require legislative action will not be our major focus. At this time, it is not our intention to consider budget reconciliation this year.

The budget summit agreement between Congress and the White House has already reduced Medicare spending by $3.5 billion in fiscal year 1989.

The President is looking for an additional $1.2 billion from the elderly's health program. This proposed reduction is a breach of faith with the Nation's elderly and with the Congress and should not be, in the Chair's opinion, seriously considered.

However, we cannot consider increases in Medicare spending beyond the existing levels for fiscal year 1989. This provides us with an opportunity to review the payment system and to assess how hospitals are reacting to it.

Recent reports reveal a number of concerns which require scrutiny.

The Chair at this point would like to reiterate the subcommittee's request for a reporting system that would be most helpful to the committee in making reasoned and careful assessments of how this aid to hospitals should work and which hospitals should receive assistance.

The DRG system was established to change the incentives in providing hospital care in order to promote efficiency and reduce cost. Surprisingly, recent studies by ProPAC revealed that costs were not reduced, but instead have risen at levels in excess of inflation.

We need to know what factors have contributed to this excessive cost growth. Some will argue that the nursing shortage is the culprit, or AIDS, or changes in the severity of illness. I suspect that the answer relates more to the decisions made by hospital managers than those factors. But I hope our witnesses today will shed some light on this critical question.

We must also be concerned about the tremendous level of excess capacity in the hospital industry. Although it is true that we have had some success in shifting care from inpatient settings to outpatient, it is hard to see how we are achieving any savings when the inpatient capacity is still sitting there unused. Lower occupancy without closure of unneeded hospitals may also be driving costs upward.

I suggested in conversation before this hearing that this may be the salvation of the airline industry. With California hospitals running half-empty, and New York hospitals running in excess of 100 percent, and the round-trip air fare on United Airlines being less than the cost of a day in the hospital, I think the obvious solution, with the cooperation of the airlines, is readily apparent. So, send us your poor and your unwanted, and California will prosper.

I am also particularly concerned about information from my own State which indicates that we have much higher costs per day and per admission, combined with this lower occupancy rate. I would not like to think that hospitals in California were so much less efficient than other hospitals, and I would hope that our witnesses could shed some light on these differences in their testimony today.

There are also a variety of less global issues with which we must be concerned. A high priority is modifications in the outlier payment system by which we reimburse for high cost or high length of stay admissions.

Without the prospect of a reconciliation bill, this session provides an excellent opportunity to stop and reflect on how well the prospective payment system is meeting the goals that were set for it.

I look forward to hearing from our witnesses on this important subject.

Mr. Gradison?

Mr. GRADISON. Thank you, Mr. Chairman.

I would like to associate myself with the remarks you have made. I, too, hope and expect that there will be no reconciliation bill this year and would anticipate it would give us an opportunity for a useful pause—not just from the point of view of the Congress, but also from the point of view of providers and beneficiaries alike—a pause that would give us an opportunity to assess the cumulative impact of the frequent changes made by Congress in recent years in reimbursement.

We know a lot about the behavior pattern of hospitals which are operating in the black and anticipate continuing to operate in the black. We know less, I would suggest, about the behavior pattern of hospitals operating in the red or anticipating operations in the red. It appears that if the American Hospital Association figures are correct, we are going to be learning a good bit about that in the months immediately ahead.

Mr. Chairman, I look forward, as I know you do, to the testimony of these outstanding witnesses, and I want to thank you for scheduling this hearing so early in the year. Giving it this priority is certainly indicative of the concerns of this subcommittee about this very important subject.

Chairman STARK. Thank you.

Mr. Coyne?

Mr. COYNE. I have no opening statement.

Chairman STARK. Our first witness is Dr. Stuart H. Altman, the Chairman of the Prospective Payment Assessment Commission. ProPAC, as it is affectionately known, is required by law to report to the Secretary on its recommendations regarding payment or payment changes by March 1.

I would like to congratulate ProPAC as being one of the few governmental or quasi-governmental institutions that takes deadlines seriously. We appreciate that. It makes it easier for us to do our work. And regardless of what your report will show, it is very refreshing to have it on time.

Thank you for being here once again, Stuart, and proceed to expand on your prepared testimony, or paraphrase it or add to it in any manner that you are comfortable.

STATEMENT OF STUART H. ALTMAN, PH.D, CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, ACCOMPANIED BY DON YOUNG, M.D., EXECUTIVE DIRECTOR

Mr. ALTMAN. Thank you, Mr. Chairman, for those kind words.

Actually, thanks to my staff, Don Young, who is the Executive Director and is on my left, we did meet our deadline of March 1, which as you know is a month earlier than previously due to the legislative change.

We were informed by our printer last night that there would be 25 copies sitting on our desks today by 9 o'clock. They have not met that deadline. In the past, the Government Printing Office somehow met the deadline, but I guess the private sector cannot keep up with the Government.

We, as you know, plan to have a June report which will go into depth about the impact of the prospective payment system on the whole U.S. health system. We will present a little of the material this morning, but much more of it will be available in June. So we appreciate very much your concern that it is now time to take stock of what impact this quite different payment system has had on our health care system.

We now have the information in much more depth than we have had in the past, and while it is not perfect, the first 2 years, we literally were flying blind.

What I'd like to do this morning, Mr. Chairman, is just briefly summarize our results. I realize that you are not planning to have a reconciliation, but I think it is important for the record that we establish what we believe appropriate increases should be.

Based on our analysis, we do recommend an average increase of 3.9 percent in the update for hospitals, which is 3.8 percent for urban hospitals and 4.6 percent for rural hospitals.

I want to make a point here that is not in my testimony. Those estimates are based on an assumption that what you as the Congress decided the end of the year increase last year would be the base that we updated. You, as you know, phased in several increases to take effect at different points over the year. If you updated the average rates for the year as opposed to the end of the year rates, it turns out our recommendation would be exactly—almost exactly, within a tenth of a point—of what is in that reconciliation bill for fiscal year 1989. In other words, we would be very close to market basket minus 2 percent.

But our assumption—we couldn't tell exactly what was in the Congress' mind—was that the end of the year rate should be updated, and on that basis the increase was market basket minus 1.2. I'll be glad to explain that in more detail if you are interested.

The second point I want to emphasize is that our estimate is based on the market basket that existed at the time we did our analysis. At that time, the market basket was 5.1 percent. There are pressures both in the larger economy and in the hospital economy that are likely to make that 5.1 change maybe significantly in the months ahead.

We understand that the most recent market basket shows a decline from 5.1 to 4.8, which was a surprise to me. The decline is mainly because of the stock market crash in October and the resulting slowdown in increases in nonwages.

On the other hand, wages are increasing faster than reflected in that market basket, and wages are increasing particularly faster for the hospital sector as a whole.

The second emphasis I want to place on our estimates is that we continue to believe, strongly, that the hospitals in this country should have additional funds for new and approved scientific and technological changes. However, we believe that it is also appropriate and prudent that most if not all of those new dollars come from increased productivity on the part of the hospital industry and not be an add-on to the market basket.

As a result, our estimates include basically a half-point increase for science and technology matched by an equal half-point reduction for new productivity. Now, I do not claim perfect accuracy, but we have tried the best we can to get a sense of what the hospitals in this country need to take on the new technological advances, and our best estimate is around a half percent in the market basket. And we have lowered our estimate of what productivity advances they can make to that half a percent. In earlier years, we thought they ought to do better. But as you pointed out in your opening testimony, we are quite surprised about how little responsiveness we are seeing on the part of hospitals in terms of becoming more productive. So we have lowered our targets to what we consider more reasonable amounts, but we would hope they would not go to zero.

When you take our estimates for PPS hospitals translate them to the exempt hospitals, we recommend a 5.2 percent increase for PPS-excluded psychiatric, rehabilitation and long-term facilities. I apologize, Mr. Chairman, that in our prepared testimony on page 4, the "5.5" was incorrectly stated; it is "5.2". And I know there was glee in certain circles, but we don't want you to be misled. One-tenth of a point is as important in Medicare as it is in the Olympics. We are dealing with significant dollars.

For children's hospitals, our recommendation is for a 5.1 percent increase.

What is becoming increasingly important, and it is the kind of activity that we spend a lot of time on, is the technical adjustments that we go through to make the system fairer.

As the PPS system tightens down—and it is doing that—fairness becomes increasingly important. When, in the first years of PPS, we were pumping extra money into the hospital system, distortions between types of hospitals were easier to deal with. But now that the system is close to or actually below cost in certain circles, it is very important that we be sure that we are paying hospitals appropriate amounts, and so we spend a lot of time trying to decide how to pay for a particular DRG, whether we should be paying an urban hospital more or less, and we are going to continue to do that.

I realize it is not always the most exciting activity, but if the country, in my mind, and the hospital system, is to believe in PPS, it needs to be viewed as being fair.

In that context, we continue to monitor closely what is the appropriate increase for teaching hospitals. What about Sole Community Hospitals in urban and particularly in rural areas? What about the disproportionate share adjustment?

We also have urged several times that HCFA adjust the labor markets. We don't believe the current labor market adjustment is right. It tends to over-reward certain hospitals, particularly those that get the urban adjustment, but are sitting there in the suburban rings, and it underpays the real urban-urban hospitals that really have to pay higher wages because of general conditions.

We also believe that the DRG system should be recalibrated based on costs rather than charges. HCFA has used charges for a few years as a quick way of readjusting or recalibrating. But now, we believe cost should be used. On the other hand, we, like you, are not happy with the quality of the cost reports. We believe they should be improved. Their timeliness should be improved as well, although they are getting better. But those costs even in the current state are as good or better than using charges.

So we would recommend that henceforth, recalibration be based on costs.

One area which is very troubling to the Commission, and which we are and will continue to spend a lot of time on, is outlier payments. Outlier payments are in many respects indirectly the source of more problems and more letters than any other single item because it is through the outlier system that you pay extra funds to those hospitals that get caught with very sick or patients whose costs far exceed the average of the DRG system.

We basically supported the change that you made on a temporary basis in the burn center DRG. We believe that you, if you will, backed into a position that even when you look at in more detail, tends to look pretty good, although we have some problems with it in the long run because you have lumped together all burn patients, and we see significant differences between patients treated by burn centers and those that are treated in general hospitals.

But the general outlier policy needs to be improved. We have made to HCFA three basic recommendations: one, that henceforth, we should not use general cost-to-charge ratios, but hospital-specific cost-to-charge, because if you use general, certain hospitals come out way ahead just by simple fact that they have jacked up their charges more on average than others, and that shouldn't be. So we believe it should be hospital-specific.

Second, we believe the dominance of the day outliers should be reduced. I won't go into the technical detail unless you are interested, but the original policy so heavily weighted outlier payments based on length of stay that it led to some hospitals reaping substantial extra moneys and some hospitals in this country really being clobbered—clobbered in the sense that they wound up with patients whose costs far exceeded the DRG payment, but they weren't in the hospital that long, and therefore they either didn't qualify at all for the outlier payment, or they got substantially less.

We are recommending this year that we begin a process of moving closer to cost. And we have used a first step. We have not recommended going the whole way, because in that case we would be talking about reallocating hundreds and hundreds of millions of dollars, and we want to be careful that what we are talking about is the right way.

We also are concerned about the total pie that should go to outliers. We believe that probably it should exceed 6 percent; that the current system actually tends to take money away from hospitals that are treating the sickest patients and giving it to hospitals that are treating the average patient. Therefore it is probably the case—and we will come back to you next year with a recommendation probably to increase the pool of outliers beyond 6 percent—but at least we should go to 6 percent. The current procedure of HCFA is to keep the outlier payments closer to 5 percent. By doing that, you keep money away from those hospitals that treat the sickest patients and put it back in the pool for the average patients.

Now let me focus my final couple of minutes on the important issue of the overall hospital financial conditions.

We have now information both from Medicare and from the AHA, looking at the payments to hospitals and their costs since PPS. In general, the financial status of the hospital industry has improved dramatically in the early years of the PPS system.

It is also fair to say that this general economic climate has declined since those early years. Nevertheless, the Commission believes that the industry appears to be in better financial shape now than it was in the 1970s. Our conclusions are based on an analysis of trends in hospital costs, revenues, and operating margins, or profits, if you will.

While the industry appears to be healthier by long run historical standards, we do have some concerns. And what we have appended to our testimony is a chart or series of tables which summarize these trend lines. In figure 2 at the end, you can see hospital operating margins. What they show is during the 1970s—I do not know if you have a copy of it handy—but during the 1970s, hospitals—the bottom line is an approximation of what they earned and what it costs to treat patients—were constantly in the red, or below the zero line, for patient margins, but the total margins were above that and averaged around 2 percent.

When we introduced PPS in the early 1980s, 1982, 1983, you see a significant jump in the margins both for patients and for total. But since 1984, these margins have come down. But the total margins are still quite healthy.

So that as an industry as a whole, you cannot say that American hospitals are financially in worse shape today than they were before PPS or surely the Seventies. However, it is also fair to say that the dispersion, the distribution of hospitals' financial positions, is much different than the seventies.

There are many more winners and losers out there today in terms of their profit margins than there were when we had cost-based reimbursement.

We do have a significant number of hospitals in this country that are facing operating margins, if not total margins which are negative. On the other hand, we have a significant number, and in table D we do show the margins, and we show that for the top 10-percent hospitals, the average profit margins are approaching 20 percent, while the bottom 10 percent have negative margins of 20 percent.

The concern that you have to face, as we do, is if we prop up—as the pressure on you will be—to prop up the bottom ones, and you leave the top ones alone, we will have a payment system which is far worse than we had before PPS.

The second statement I would make is if we as a country, if you as the Congress, dictate that we should protect a particular hospital profit margin, we have crossed the line between a rough competitive system to a regulatory system. And then the next question you will ask, because we will ask, is if we are going to prop up profit margins at a particular amount, the next question you should ask is: I want to look at your costs. I want to know what you are spending your money on.

We don't recommend a particular number. That does not mean we should not review those margins. And we did review them and therefore recommended an increase which was more liberal than we had in the past. But we have tried to avoid saying hospitals in this country should on average have a 4-percent margin, or every hospital should have it. That would be the worst of all worlds.

So I realize the pressure on you. The pressure is on us as well. And we will continue to monitor that situation. My feeling is that, as you pointed out in your testimony, the main issue/problem is that costs are going up significantly faster, not only than the market basket, but faster than any other segment that I know of.

Part of the reason, you can explain, and that is this system does not adjust for volume. And as the volume of patients have gone down, hospitals either cannot or have not responded by like reductions in costs.

It is also fair to say that hospitals are treating sicker people; as we move the least sick or the less intense to outpatient treatment, those that remain are sicker. But again, you cannot justify all of the cost increases based on that. There is that third component.

The third component is what is driving the hospitals to continue to pay higher costs. Why are they not responding? Can they respond?

I think the pressures on them are intense. We continue to see all-R.N. staffs. We talk about a nursing shortage in this country, like there are not nurses practicing. We have more nurses practicing today in hospitals than ever before. I know many nurses personally; I have talked to them. They feel they are working harder than they have ever worked before. That is probably true, because we asked more of them. Many of them are quite frustrated, because they are being asked to do more and more nonnursing activities.

But the problem is not that we don't have enough nurses. We don't have enough nurses relative to the fact that just 10 years ago we had half a nurse for every patient, and now there is practically one R.N. nurse for every patient. And we have eliminated the whole bottom level of what used to be the delivery system, the L.P.N.s and the aides. Many hospitals have almost none of them.

Now, maybe that is good for quality of care. But I think we need to take a hard look at that, because ultimately to do that requires a payment system from the government and from corporate America which is going to have to go up significantly faster than in your reconciliation bill and in our recommendation.

My own view is that in the long run, the nursing shortage is going to be a supply problem. Young women and young men are not going into nursing in the numbers that they were before and surely not in the numbers that would be needed to maintain all-R.N. staffs. Hospitals in this country are going to have to, whether they like it or not, change the way they do business.

I am not here to tell them how to do it, but there is no question in my mind that a new type of hospital care delivery system needs to come into place which makes less use of the most expensive type of personnel, better balances.

So in conclusion, Mr. Chairman, I think we are at a critical point from the point of view of the Congress, and that is do we guarantee hospitals a certain profit, a certain rate, or do we establish an appropriate rate as we see, given the ability of the Congress and the people to pay for it, and then ask the hospitals to develop a delivery system in line with that payment. That really, in my mind, is the issue; which drives the system—the costs or the payments?

Thank you very much.

[The statement of Stuart Altman follows:]

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Thank you for inviting me to describe ProPAC's 1988 report and recommendations on updating the Medicare prospective payment system. It is always a pleasure to appear before the subcommittee and to work with you, Mr. Chairman. Accompanying me today is Donald Young, M.D., the Commission's Executive Director.

Let me begin by mentioning that we are following a slightly different time schedule for our reports and analytic work this year. Our schedule has changed in response to your statutory request that we complete our PPS report to the Secretary by March 1 instead of April 1, as it was in previous years. Our annual report to the Congress on the impact of PPS, Medicare Prospective Payment and the American Health Care System, was previously issued in February. It will now be published in June. Our detailed analysis of hospital financial condition and broad information about changes in the financing and delivery of health care will appear in the June report.

March Report Recommendations

Our March report was printed over the weekend and delivered to the Secretary today. We have provided copies to you and the staff. This morning I'll describe our major recommendations, particularly those which involve updating the PPS payment amounts for 1989 . The full report contains many additional recommendations -- 18 in all -- and I'll be glad to describe any of the others in detail or answer questions about them. In addition to the Report itself, we'll publish shortly a volume of Technical Appendixes containing additional background analysis.

Recommended PPS Update for Fiscal Year 1989

As I noted, the Commission has just completed its recommendations for updating PPS payment for next year. ProPAC has recommended updating payment amounts an average of 3.9 percent in fiscal year 1989. That amount results in an update averaging 3.8 percent for urban hospitals and 4.6 percent for rural hospitals.

This recommendation combines several components. The largest is the PPS market basket, which estimates inflation in prices of goods and services purchased by hospitals. When the Commission made its recommendation, the market basket was forecast to increase 5.1 percent in fiscal year 1989. More current forecasts will be available before next year's rates are set.

Other components considered by the Commission include adjustments to take into account recent scientific and technological advances, the potential for improvement in hospital productivity, and changes in the types of patients treated by hospitals (called hospital case mix). The second year of a three-year phased reduction of the standardized amounts is also included. This reduction is intended to adjust PPS payments to account for differences between first-year PPS costs and the projected costs that were used to set the original PPS payments.

After considering each of these factors and making judgments about each of the components I have described, the Commission concluded that in fiscal 1989 PPS hospitals should receive an average increase in Medicare payments that is about 1.2 percent lower than the market basket rate of increase. This indicates the Commission's overall belief that most hospitals can continue to provide access to high quality care for Medicare beneficiaries with a payment increase that is slightly less than the rate of inflation.

Based on the currently projected market basket inflation rate, we have recommended an update of 5.5 percent for PPS-excluded psychiatric, rehabilitation, and long term facilities. For children's hospitals, our recommendation is for a 5.1 percent increase.

Other recommendations in our March report advise adjustments to PPS and to the DRGs which we believe will technically enhance the system and distribute payments to hospitals more equitably. As I will discuss, PPS payment policies have had significant distributional effects on the hospital industry. As hospitals face increasing financial pressures, it is important to continue to improve the distributional policies. Our report includes a number of recommendations that will not affect total Medicare payments but are nevertheless extremely important.

Other Recommended Adjustments and Changes

The Commission is recommending several technical improvements to PPS concerned with adjusting the payment formula and revising DRGs to better reflect relative resource use. In particular, we reiterate our call for improvements in hospital labor market area definitions. These definitions substantially affect the distribution of hospital payments because they are used to apply the area wage index adjustment to PPS prices for every hospital. The Commission remains convinced that the current definitions are seriously flawed and can be substantially improved with existing data.

We suggest further study and assessment of indirect teaching, disproportionate share, and Sole Community Hospital (SCH) policies. We believe that the indirect teaching and disproportionate share adjustments should regularly be assessed with current data to monitor the relationship between teaching and service to the poor and Medicare costs. We have also recommended further assessment of Sole Community Hospital policies and improvement of SCH criteria.

ProPAC continues to believe that DRGs are still the most appropriate measure of hospital case mix for PPS. We believe that available data can be used to refine and improve the DRG system.

The Commission recommends recalibrating the DRG weights on the basis of costs rather than charges. At the same time, we question the accuracy of the DRG-level estimates derived from Medicare billing and cost report data. Thus, while recommending the implementation of cost-based weights in fiscal year 1989, we advise that the Secretary should take steps to verify and improve the accuracy of the cost report data and methods of adjusting charges to estimate costs.

We also recommend changes in DRG assignment for certain cases in DRG 468, which contains all cases with surgical procedures unrelated to the principal diagnosis. ProPAC believes that most cases should be reassigned to existing DRGs on the basis of secondary diagnosis.

We recommend changes in outlier payments for burn DRGs, as well as changes in general outlier payment policy. We believe that current outlier payment policy is inadequate and ought to be substantially reformed. We have recommended movement to hospital-specific cost-to-charge ratios for calculation of cost outlier payments. We also believe that greater emphasis should be placed on costs rather than on length of stay, as is now the case. In addition, the Commission believes that consideration should be given to devoting a higher proportion of total PPS payments to outliers than current law allows. We will continue our analysis of outlier payment policy and work with the Secretary in any way possible toward the goal of improvements which are supported by thorough analysis.

Finally, the Commission has reiterated its concern that the Secretary should initiate a comprehensive evaluation of the Peer Review Organization quality of care activities.

Overall Hospital Financial Conditions

Because the subject of the general condition of hospitals has such an important bearing on our work and on your review of Medicare PPS payment policy, let me mention in more detail our analysis of this subject. The Commission began monitoring hospital financial condition, including hospital operating margins, several years ago when we studied the distribution of PPS payments. We believe that a major part of our responsibility relates to assuring that PPS does not adversely affect access to quality health care for Medicare beneficiaries, and that means that hospitals must receive adequate compensation for treating Medicare patients under PPS. We also, however, need to be concerned about the continued growth of Medicare expenditures and about the Federal deficit.

The financial status of the hospital industry as a whole improved dramatically in the early years of PPS, but has declined since then. Nevertheless, the Commission believes that the industry appears to be in better shape now than it was in the 1970's. Our conclusions are based on analysis of trends in hospital costs, revenues, and operating margins, or profits. While the industry appears to be healthy by long-run historical standards, we have several concerns.

First, comparison of current overall industry margins with past measures may not be entirely appropriate. The introduction of PPS and other per-case payment systems was intended to give hospitals the opportunity to generate a surplus. It also, however, was designed to place them at greater risk. The threat of financial loss provides the pressure for increased hospital efficiency and productivity.

Another concern is that overall average margins mask variations at the individual hospital level. Because of the riskier environment hospitals face, there is a wider range of operating margins than in the past. That means, however, that while some individual hospitals experience losses under PPS, others have profit margins that are quite high.

Finally, the downward trend in margins appears to be continuing. We need to understand this trend better, because as more hospitals incur losses under Medicare, Medicare beneficiaries could begin to experience problems with access to care.

While Medicare payments have been tightened in recent years, the more important reason for declining margins is a dramatic increase in costs per case. This increase is due partly to the fact that hospital admissions have dropped and hospitals are treating fewer inpatients. As a result, the percentage of hospital beds that are empty is increasing. In addition, since the simplest cases are no longer being admitted to the hospital, the cases that remain in the hospital are, on average, sicker than before. But these explanations don't completely explain this large increase in costs per case.

We are very concerned about the higher costs because we have seen few signs recently that hospitals are changing their behavior in response to reduced demand for inpatient services, and in response to incentives to increase productivity and efficiency. Until we more fully understand why the rapid cost increases have occurred, the policy implications of declining margins are not clear. ProPAC will be carefully monitoring these cost increases and their impact on margins.

I have attached to my testimony a chart developed by ProPAC and based on data from the AHA which depicts hospital operating margins over the years 1970-1987. We believe that this chart, and the accompanying chart showing hospital revenues and expenses per case for 1971-1987, give an interesting picture of changes over a long period of time. The information on current PPS hospital margins should be considered in light of this historical pattern. In addition, we have also attached tables showing data on Medicare margins over the first three years of PPS.

ProPAC Data on Hospital Margins

Our information is calculated using Medicare Cost Report data from a representative subset of hospitals for the first three years of PPS, 1984-1986. We combine information about revenues paid to the hospital under PPS and expenses incurred by the hospital in treating Medicare patients.

Our analysis indicates that first-year PPS margins for hospitals were 14 percent; second year margins were about the same; and, third year margins were about 8 percent. We do not have specific Medicare cost or revenue data for 1987, but our best guess is that the average PPS operating margin probably fell to about 2 percent. Predicting 1988 is mostly guesswork. However, we can say that even if cost increases are reduced substantially, it is likely that the average PPS margin will fall below zero. We will present additional data and discuss our findings on hospital financial conditions, health care expenditures, and service utilization in our June report to the Congress.

Congressionally Mandated Reports

Mr. Chairman, before I close I want to add a few comments about the reports you have requested ProPAC to complete. OBRA 1987 required Commission study and reports on a number of important topics in the relatively near future. Since this legislation was enacted, we have begun the work necessary to complete the studies and reports, even though the majority of both Commission and staff time has been allocated to analysis and publication of our March and June reports. The Commission's next two meetings are in April and June. We will be reviewing preliminary findings and providing guidance to the staff in developing the reports required by OBRA at those meetings. As a result, it is likely we will not be able to meet some of the early deadlines scheduled for this spring. We will, however, report to you as quickly as we can. I would be happy to provide you and your staff any additional specific information about our plans and progress on individual studies.

Conclusion

Mr. Chairman, I appreciate the opportunity to describe our recent report and recommendations, and some of the other work we have underway. I will be glad to provide further information on any of these topics, or answer questions you may have at this time. We look forward to continuing our close working relationship with you and the Committee staff.

FIGURE 1

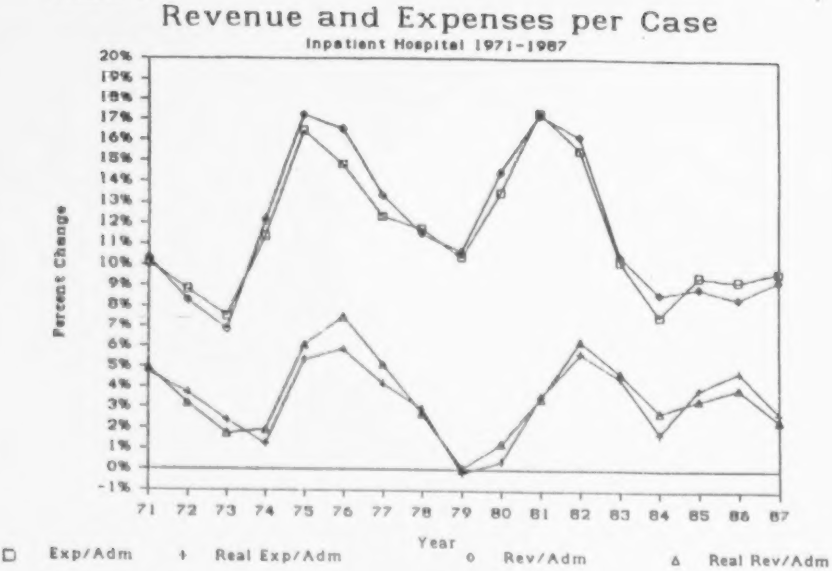
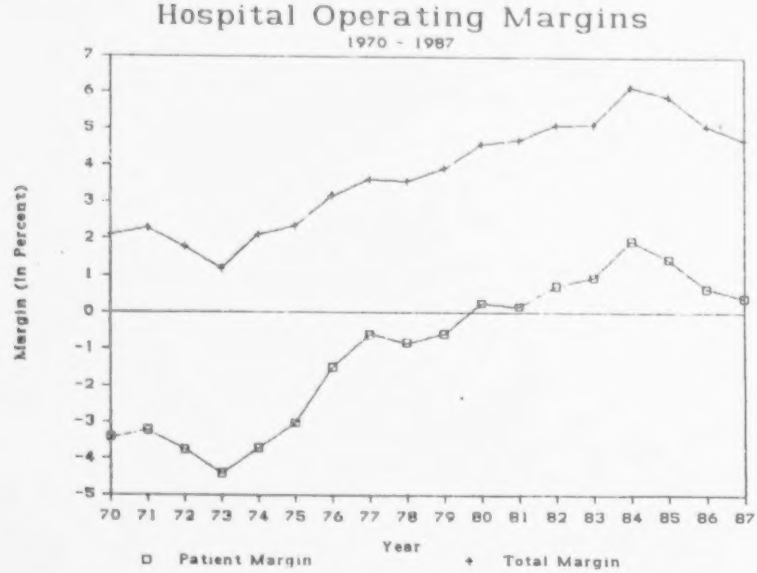


FIGURE 2



Source: ProPAC anaylsis of AHA Panel Survey Data

TABLE A. Percent Change in Aggregate Medicare Operating Costs, Cases, and PPS Revenues for the First Three Years of PPS

	TOTAL OPERATING COSTS	PPS REVENUE	CASES	COSTS PER CASE	REVENUE PER CASE
TEFRA TO PPS1*	5.2	11.0	-1.1	6.4	12.2
PPS1 TO PPS2	3.0	3.3	-6.3	10.0	10.3
PPS2 TO PPS3	6.5	-0.6	-3.6	10.4	3.0
PPS1 TO PPS3	9.7	2.6	-9.7	21.3	13.6
AVERAGE	4.7	1.3	-5.0	10.2	6.6

TABLE B. Aggregate PPS Operating Margins for the First Three Years of PPS

	PPS1 "FY 84"	PPS2 "FY 85"	PPS3 "FY 86"
PPS REVENUE PER CASE	$3332	$3675	$3786
MEDICARE OPERATING COSTS PER CASE	2865	3150	3477
PPS MARGIN (percent)	14.0	14.3	8.2

SOURCE: Preliminary ProPAC estimates based on Medicare Cost Reports for 2233 hospitals. Excludes hospitals in Maryland, Massachusetts, New Jersey and New York.

* Estimates for the TEFRA to PPS1 change are not strictly comparable with the rest of the table. In particular, the 6.4 percent cost per case increase is the average annual change from 1981 through PPS1.

TABLE C. Percentile Distribution of PPS Operating-Margins in the First Three Years of PPS (PPS margins in percent)

	PPS1	PPS2	PPS3
10th Percentile	-5.5	-7.1	-23.2
25th Percentile	3.1	2.7	-5.0
Median	10.8	11.0	4.9
75th Percentile	17.0	18.0	12.5
90th Percentile	22.2	24.6	19.8

TABLE D. Percent of Hospitals with Negative Operating Margins in the First Three Years of PPS

	PPS1	PPS2	PPS3
PPS/MEDICARE MARGIN	18.0	18.6	36.8
TOTAL MARGIN	19.6	23.2	30.5
PATIENT MARGIN	39.6	47.4	55.1

SOURCE: Preliminary ProPAC estimates based on Medicare Cost Reports for 2233 hospitals. Excludes hospitals in Maryland, Massachusetts, New Jersey and New York.

Chairman STARK. Thank you, Stuart, very much.

I'd like to just touch on a couple of points. First of all, I think it important that your testimony be understood beyond at least the staff of this subcommittee—it sounded to me like you said that 3.9 percent equals 3.255 percent. It is not the algebra that I recall, but it is basically, a different baseline, and that what in fact you have said is that the bill that this Congress reported out last calendar year comes pretty close to establishing the increase that you would recommend for fiscal year 1989.

Is that a fair statement?

Mr. ALTMAN. Yes. Let me try again. I realize it was complicated——

Chairman STARK. I just wanted to repeat that, to establish it in the record.

Mr. ALTMAN. This year, the Congress gave hospitals increases in three increments, and then it ended up where the last average increment was like 1.6 percent.

We built our recommendation on that last number. But if we had built it on the average of all three increments for the whole year, our increase would have been less. The reason why we built it that way is we couldn't read your minds. We didn't know whether you wanted those lower payments to be carried through forever.

There was an equally legitimate argument that said you did those lower rates for one year for budget purposes. So what we did was we assumed that it was for one year, and therefore that's why the 3.9 is there. But prudence dictates that we tell you what we did, and then you basically tell us back what you want.

Chairman STARK. Thank you.

Do you believe in institutional euthanasia?

Mr. ALTMAN. Well, it depends on whether it is done explicitly or implicitly.

Chairman STARK. You raised a question that probably brought joy to the hearts of everyone who makes CAT scanners and other expensive equipment by suggesting that we plug in a factor for science and technology. I am concerned that we take different approaches in different areas of utilization of capital. I suspect that how labor is used in various areas is something that the Congress really cannot quantify. It does become apparent on either occupancy rates or the number of CAT scanners that, for some competitive reason, we are not using our capital resources in a very even manner. And again, I don't know that this committee has to answer that, but it seems to me that in some areas there is tremendous overcapacity, and there is expansion for reasons that don't make economic good sense. They may make institutional sense because of institutional pride, and the instinct for the institution to survive, but they just don't make sense on an overall basis.

Do you have any suggestions as to what we might do to correct this imbalance?

Mr. ALTMAN. Well, Mr. Chairman, I think a first hearing might imply that we may have made all the technology people happy. But the second sentence takes it back. Essentially, what we are recommending is that all scientific and technological improvements be funded through increased productivity of the industry.

So in a way we are recommending—I think what you are saying—and that says if you want to buy a new MRI, or you want to add TPA drugs, we are not recommending an increased amount of money; we are recommending that you use existing technologies more efficiently, take the savings from that and put it for the new stuff.

So in fact I think we have recommended just what you said.

Chairman STARK. How about new buildings?

Mr. ALTMAN. Well, we have, as you know, for several years now recommended that capital be included in the DRG payment. The Congress has seen fit not to do that. Interestingly enough, if you will excuse me, you are backing into a policy that from an economics point of view, I now view what you have done is told the hospitals that they have a 15 to 20 percent coinsurance rate on capital. And while I still would prefer it to be included in the DRG payment, what you have done is to say to them they no longer can count on that as a cost passthrough, and therefore there had better be other revenues that justify that capital.

So I am becoming personally more sympathetic to the approach that the Congress is using all the time. When you get to 20 percent, I think you'll be just about right. I still believe it ought to be for other purposes under the DRG, but I think we have ended cost-based total on capital, and I think that is a plus, because it was creating a distortion between labor and capital, where capital got paid everything, and labor just had to take its shot any way it wanted, and that was not fair.

Chairman STARK. So you would suggest that we stick to the DRG rate as opposed to, dealing with utilization——

Mr. ALTMAN. Well, when you put it in the DRG, you are dealing with utilization. The DRG is a very tough taskmaster on utilization. It says: One less patient, one less amount of money. And in the old days, as you know, under cost-based reimbursement, if you built a building, and your utilization fell by 50 percent, those that were left got an increase of 50 percent. The new DRG system says if it falls by 50 percent, you lose 50 percent of your revenues.

So the DRG system is a tough utilization taskmaster, and I cannot believe any hospital would consciously add new capital in a DRG environment given the fact that it does not have the patients to fill them.

Chairman STARK. Come to California.

Mr. ALTMAN. Well, I think California built most of those facilities before the DRG system.

Chairman STARK. Yes, but I'm talking about present plans. How does that system work with the New York situation where there is 110 percent occupancy and probably a statewide average of over 90 percent compared to California, which has under 60 percent. And then you take hospitals in affluent suburbs in California running under 60 percent who decide to build additional space 10 miles away because they are afraid they will lose a prospective market.

How will the DRG system deal with that next year?

Mr. ALTMAN. Well, by selecting New York and California, you in my mind have selected the two extremes of the American health care system.

New York, to the extent that I understand it—and I have been part of it indirectly for a long time—New York had the toughest, most effective regulatory system in this country during the 1970s. They were pressed to do this by a financial condition, you know, that practically sent them into bankruptcy.

What they did was to feed on themselves, and there was almost no new capital growth in New York hospitals for a 10- to 15-year period. That is so different from the rest of the country. The hospitals in New York, it is fair to say, are not in great shape. They are quite shabby. I have been there. They are not the kind of hospitals, generally, I think most Americans want to go to today.

So it is true that, (*a*) they have cut back the number, plus (*b*) they have not built. They now have on the books billions and billions and billions of dollars, more money than I can count, to all of a sudden modernize their whole hospital. That is the first thing.

California and the others have been much more gradual.

But more importantly, New York is the most imbalanced delivery system I think we have. They have the least-well-developed alternative to institutional care system, for lots of reasons. They have less HMOs. They have less home care. They have less ambulatory care. You see that very dramatically on comparing how New York City and San Francisco treat AIDS patients.

Now, it is true that the AIDS patients in New York are much more driving by drugs, needles, and so on than San Francisco. But that's not the whole answer. The reason is New York lacks an alternative to an institutional delivery system. So what you see in New York is long lengths of stay, high occupancy, old facilities.

California, on the other hand, puts a hospital at the end of every freeway exit. It is almost like—I don't know exactly why. They are smaller. They can operate efficiently, I have been told, at 50 percent capacity. So the numbers just don't mean the same. They are not staffed up.

You know much more about California than I do, but I think by selecting those two States, you can ask, what do I want the rest of the country to look like.

Chairman **STARK**. Have you analyzed where the hospital margins would be if the costs had risen at a level closer to the long-term trend?

Mr. **ALTMAN**. If the costs had risen?

Chairman **STARK**. If costs had stayed closer to the long-term trend rather than the jump they took, have you analyzed what the hospital margins would be?

Mr. **ALTMAN**. No. What you are saying is that on a cost-per-admission basis, costs have gone up in the last couple of years faster than long-term trends. I believe a lot of that has to do with volume. In the old days, volume was a complete adjuster. We chose in DRGs not to adjust.

I think if we adjusted for volume, we would not bring the costs down to the market basket, but I suspect we would bring them much closer to historical trends. As a matter of fact, I wouldn't mind doing that—we haven't done it, but my hunch is that one of the reasons why those costs look so out of line is that there is no volume adjustment in them.

Chairman STARK. In your chart on figure 1, Revenue and Expenses per Case, you have three very distinct drops—1974, 1979, and 1984. Do you have a "7-year locust" theory or some other explanation?

Mr. ALTMAN. Well, 1974 was the economic stabilization program, which went on basically from 1971 to 1974. The drop isn't only important, but while you are focusing on that, what is more interesting to me is that 1971 to 1974 is the only period other than 1983 to 1984—not the only period, but one of the few periods—where you have costs—let's see, during that period of time, initially revenues are above costs, and then in 1974, costs go higher than revenues. So if you look at that 1974 period, you have the costs, which is that little triangle, higher than revenues.

That is the same thing that happens beginning in 1985. You have a big drop in revenues and then costs jump up faster. So there is a similarity between the economic stabilization period and the PPS period.

In 1979, to give the provider community their due—and this might be the same explanation as the locust theory—was that this was the period when all of the hospitals and Blue Cross and the insurance and doctors all got together and said if the government stays out of it, we will do this voluntarily. And I think they did it for a year.

I think what it showed, though, is the same thing that happened in the controls. We took the controls off in 1974, and the system jumped back up, and the voluntary system fell apart once the pressures hit them.

The truth is that the medical spending imperative is so powerful in this country, in my view, that it overwhelms the poor regulatory systems we put in its place, and the half-hearted competitive pressures.

I have just finished a paper on that. We just are unwilling as a country to allow either regulation or competition to control spending, because either of them involve losers. My sense is that collectively, it is not only here, but also on the business side, we are really unwilling to allow losers to last in the system for very long, and so we wipe out competition if it causes problems, and we wipe out regulation when it causes problems. That is what you are seeing here.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

Last year in the reconciliation bill, we saw continuation of a trend that has happened as PPS has squeezed down on payments to hospitals—more and more groups of hospitals being formed to lobby for particular changes to meet their special circumstances; the rural-rurals, the urban-rurals, the rurals versus the urbans, the disproportionate share, the teaching versus the non-teaching, large city versus small city, and so forth. And we were, as I supposed we are paid to be, responsive in general to these pressures.

Did we get far off-base in what we did in the end? Were some of those changes made really not supportable other than from a political point of view?

Mr. ALTMAN. I don't know, and I honestly don't know. The last set of changes that you made sort of took us by surprise, and that was the creation of a third category. We do believe that there was some justification—there was a clear justification in separating out the rural from the urban, and we did that mainly because of the gap in the first year of PPS where urban hospitals just did much better than rural, and to have taken an average from all would have been unfair to rural. So our recommended differential urban to rural was only to last for 3 years, and we are now in the second year of that. That's why we recommended it.

But you created another category. Now, you may be right, and you may be wrong, and we are going to study that. I honestly can't tell you.

Mr. GRADISON. Well, I am happy to know you are going to study it. It would be helpful to have your recommendations on that as on these other subjects about which you have already testified.

How about the nonlabor issue, one that has separated us up here? Are you looking into this, and in general what is your view?

Mr. ALTMAN. Yes. Again, it is an area where there is, as in most cases of good lobbying, some justification for it. We have not studied it completely, so I'm not completely in a position to do it.

We do plan to give a report on this by October 1st of 1989. That is when we have been mandated to do it. But again, it caught us a little by surprise, because the level of difference did not appear to us to be an area that required immediate adjustment.

Mr. GRADISON. It caught some of us by surprise one night here, too.

Mr. ALTMAN. But it may turn out that the advocates were right. I don't think they were right in the adjustment. I mean, using wage differentials and adjustment for the nonlabor has to be a little excessive. But there are cases where I, as a matter of fact, personally, recommended to look at what I called regional market baskets, which would have been an alternative way of doing this. In the early stages of PPS, I was persuaded rather forcefully by the evidence and the articulateness of my staff and HCFA that there really were not justification for regional market baskets.

But that is in fact what is really happening here. And if you are going to do it, what we ought to develop are regional or subregional market baskets, because there can be differences both in prices and in how resources are used in a hospital. But the quick fix one, I suspect, probably—my sense is it would have overcompensated for potential problems.

Mr. GRADISON. The American Hospital Association has developed a major recommendation for changes in the way in which reimbursement to hospitals takes place under the PPS system. Have you done an analysis of their recommendations as yet?

Mr. ALTMAN. No. They were nice enough to get us their recommendations. They were done over the weekend and slipped into our mailboxes in the wee hours of the morning before our last meeting. And I did read it, but there was no time for us to really talk about it.

My impressions are that there are some real dangers in what they recommend. My sense is that they are recommending a system which, on aggregate, forces us back to cost-based reimbursement. It basically says you make adjustments through the years based on our best shot, and then at the end of every 4 or 5 years, you look at what costs really went up, and to the extent that they went up more, you pay them what the difference was.

And, while it may not be hospital-by-hospital cost-based reimbursement, it really begins to look a lot like system-wide cost-based reimbursement. And I personally would have trouble recommending that.

Mr. **Gradison**. Do you anticipate that ProPAC will take a look at this and give us a written recommendation on it?

Mr. **Altman**. Oh, yes, yes.

Mr. **Gradison**. Very good. Thanks for your extremely helpful testimony.

Thank you, Mr. Chairman.

Chairman **Stark**. Mr. Coyne?

Mr. **Coyne**. Thank you, Mr. Chairman.

Mr. Altman, the hospital industry has advanced the argument that the annual update ought to be an increase to the market basket share and that anything less constitutes an inadequate reimbursement for them.

Do you agree with that, or is that inaccurate?

Mr. **Altman**. Well, I think that over time, to the extent that a number of other things happen, having an update factor which approaches the market basket is fair. But we first need to deal with these other issues like coding. We have to make sure that through some mechanical genius, we are not winding up paying a lot more than we think we are paying. That is what happened during the first 3 years of the PPS system. We'd fight over tenths of a point, and then the payment level goes up by 4 and 5 percent more than the market basket.

So the first big caveat is I would support market basket if we got the rates so that they flattened out and there were no games being played. I'm not suggesting that they are illegal, but that they do add to higher payments. So that's the first thing.

The second thing that I think is important is that we clearly get the inflated revenues in the first year out of the system, because that was an error in the overshooting of the market, and that is where we have been recommending they be phased out over 3 years.

So, once that is taken care of, and third, that we make sure that we are being technically accurate in how we pay our hospitals—that we are fair; that we don't penalize certain hospitals like we seem to be doing with outlier payments or in certain other areas. But if we can get the system fairer, and we have taken care of those other things, then a long run trend of payments—payments, now, not the update factor—that approaches the market basket, provided we understand volume would be a reasonable system.

Mr. **Coyne**. Your testimony suggests further study and assessment of the relationship among teaching hospitals, service to the poor and Medicare costs. I wonder if you could elaborate on that relationship and tell us if you have any specific recommendations to make here today?

Mr. **Altman**. Well, let me start with the end. We are studying the teaching adjustment issue again, and plan to bring back before you next year a much more detailed recommendation.

There is no question that the teaching adjustment is now a subject of much concern. It was very hastily put together in the early stages in the beginning of PPS as an attempt both to adjust for legitimate costs of teaching, the extra costs, and also in recognition of the fact that our teaching hospitals disproportionately treat sicker people, low-income people. It became a catch-all for a whole variety of areas that we knew the PPS system was not adequate.

Well, we over time collectively have been trying to adjust for those through the disproportionate share, through trying to make the DRG system more accurate. And if we change outlier payments, then as you begin to do all these things, it is appropriate to look at that teaching adjustment and to phase it down or add to what is in fact the true, legitimate cost.

We have recommended that that should be looked at each year. We are not in a position to support or to attack what we understand the administration's position is in terms of an attempt to move quite substantially back from where the current payment is.

Our evidence, even fragmented, isn't quite so dramatic. But I'm not in a position, nor is the Commission today, to give you any firm numbers.

Mr. COYNE. You recommend a market basket increase currently estimated to be 5.1 percent for children's hospitals, but 5.5 percent for some of the others——

Mr. ALTMAN. Excuse me. It should be 5.2 percent. That was a typo error. So they are almost the same.

Mr. COYNE. I wonder if you could explain to us the reason for the difference between children's hospitals and other hospitals?

Mr. ALTMAN. Well, basically, I think you need to look at three. We have recommended an average of 3.9 for PPS hospitals, and then we have recommended 5.2 and 5.1. The difference between the 3.9 and the 5.2 or 5.1 basically relates to the comment I made before. We are taking out of PPS hospitals those extra payments that were done in the first year where PPS hospitals benefitted by these extra payments, where the exempt hospitals did not; they were under TEFRA and that complicated cost formula.

So the difference over time will narrow between the two.

So it is a very slight difference, and it is based on a different market basket.

Mr. COYNE. Is it solely because of labor differences?

Mr. ALTMAN. Well, there are a few others.

Dr. YOUNG. The market basket for the children's hospital is the same as for PPS hospitals, reflecting the kinds of services furnished in acute care hospitals. The market basket for the psychiatric rehabilitation and long-term care is a different market basket because the mix of services furnished in these hospitals is very different than short-term acute care hospitals. So it is a different mix of labor and other services.

Mr. COYNE. Thank you.

Chairman STARK. Stuart, as usual, this is refreshing testimony. We appreciate the work that you and your staff have done and look forward to working with you during the rest of the year. Thanks very much for your testimony.

Mr. ALTMAN. Thank you, Mr. Chairman. I just would like to make one further comment.

Table A, if you don't mind, we would like to supply you with an updated Table A. There were some technical problems in the way it was put together.

Chairman **Stark**. Without objection, you can revise and extend your prepared testimony, and the staff may have some written questions to submit, and you could send your answers to those along with your revisions. The record will stay open for your submission.

Mr. **Altman**. Thank you very much.

Chairman **Stark**. Thank you very much.

[The following was subsequently received:]

TABLE A. Percent Change in Aggregate Medicare Operating Costs, Cases, and PPS Revenues for the First Three Years of PPS

	TOTAL OPERATING COSTS	PPS REVENUE	CASES	COSTS PER CASE	REVENUE PER CASE
TEFRA TO PPS1*	5.2	11.0	-1.1	6.4	12.2
PPS1 TO PPS2	3.0	3.3	-6.3	10.0	10.3
PPS2 TO PPS3	6.5	-0.6	-3.6	10.4	3.0
AVERAGE*	4.9	4.5	-3.7	8.9	8.4

TABLE B. Aggregate PPS Operating Margins for the First Three Years of PPS

	PPS1 "FY 84"	PPS2 "FY 85"	PPS3 "FY 86"
PPS REVENUE PER CASE	$3332	$3675	$3786
MEDICARE OPERATING COSTS PER CASE	2865	3150	3477
PPS MARGIN (percent)	14.0	14.3	8.2

SOURCE: Preliminary ProPAC estimates based on Medicare Cost Reports for 2233 hospitals. Excludes hospitals in Maryland, Massachusetts, New Jersey and New York.

* Estimates for the TEFRA to PPS1 change are not strictly comparable with the rest of the table. In particular, the 6.4 percent cost per case increase is the average annual change from 1981 through PPS1. The actual increase in costs during the first year of PPS was probably lower.

TABLE C. Percentile Distribution of PPS Operating Margins in the First Three Years of PPS (PPS margins in percent)

	PPS1	PPS2	PPS3
10th Percentile	-5.5	-7.1	-23.2
25th Percentile	3.1	2.7	-5.0
Median	10.8	11.0	4.9
75th Percentile	17.0	18.0	12.5
90th Percentile	22.2	24.6	19.8

TABLE D. Percent of Hospitals with Negative Operating Margins in the First Three Years of PPS

	PPS1	PPS2	PPS3
PPS/MEDICARE MARGIN	18.0	18.6	36.8
TOTAL MARGIN	19.6	23.2	30.5
PATIENT MARGIN	39.6	47.4	55.1

SOURCE: Preliminary ProPAC estimates based on Medicare Cost Reports for 2233 hospitals. Excludes hospitals in Maryland, Massachusetts, New Jersey and New York.

Chairman STARK. Our next witness is Michael Zimmerman, the Senior Associate Director, Human Resources Division, U.S. General Accounting Office.

Welcome back to the committee, Mike. We have your prepared testimony, and if you would like to summarize it, expand on it, read it, present it in any manner you are comfortable—please proceed.

STATEMENT OF MICHAEL ZIMMERMAN, SENIOR ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY THOMAS DOWDAL, GROUP DIRECTOR, AND TERRY DAVIS, PROJECT MANAGER

Mr. ZIMMERMAN. Thank you very much, Mr. Chairman.

We are going to take a couple of moments here and set up a couple of charts that we brought along with us. While I am doing so, let me introduce the people who are with me here today.

To my right is Mr. Dowdal, who is in charge of our Medicare prospective payment work. And Terry Davis, who will be joining me in a moment, was responsible for the project that we are going to discuss with you today.

We are pleased that you asked us to be here today to discuss the results of several studies that we have done that looked at whether Medicare's PPS rates are reasonable from the Government's perspective and equitable from the hospital's perspective.

When PPS began in fiscal year 1984, the initial rates were based on unaudited cost data and utilization data from fiscal year 1981. Between September 1983 and March 1986, we issued a series of reports discussing the inadequacies of these data bases and why they inflated PPS rates.

We recommended in March 1986 that HHS rebase PPS rates using cost data that reflect hospital behavior under PPS. HHS basically responded that it would study the problem. Rates have not been rebased, and we continue to believe they should be.

Since the establishment of PPS, rates have had four annual updates. These updates involved numerous adjustments that were designed to assure that the rates met the requirements of the statute to provide payments sufficient to cover the costs of efficiently and economically furnishing needed services.

These adjustments were often based on estimates and incomplete data. Because of this, we do not know the relationship between PPS rates and the costs of efficiently furnishing services. But we do believe the Government should know what the relationship is because it is vital to knowing whether rates are reasonable.

As you know, much has been said over the last few years about hospital profit margins from their Medicare business. We were not surprised when hospital profits were reported as being high because, in our opinion, there was a lot of fat built into the PPS rate-setting data bases and it should not have been difficult for hospitals to make a profit. We believe rebasing the rates should show how much of the fat has been cut out and would give the Congress a better understanding of the reasonableness of PPS rates.

I know it may seem that we are kind of in a time capsule on this point. We have followed the debate over the past 4 years, and frankly, we don't see anything that has been said or taken place that has changed our minds on the issue of rebasing.

In response to your question of whether PPS rates could be made more equitable, the short answer is yes. We are in the final stages of preparing a report on the equity of PPS rates as measured by the intra-DRG variation in average treatment costs for the various diagnoses and procedures covered under individual DRGs.

As you know, one of the primary goals of PPS is equitable payments to the hospitals that treat Medicare beneficiaries. To achieve this goal, it is important that the DRG case classification system accurately group patients with similar treatment costs. We measured the variation in treatment costs within each DRG and found that in 1985, this intra-DRG variation was very high for 148, or about one-third, of the DRGs.

The first chart shows the expected normal distribution of charges for two DRGs to illustrate the difference between a DRG with low variation in treatment costs and one with high variation.

As shown, DRG 39—the one that is a solid line—had a low variation. This DRG had an overall average for all its procedures of about $2,300, and the average for individual procedures ranged from about $2,000 to $2,500, a relatively narrow spread of about $500.

On the other hand, DRG 442—the dashed line—had a wide variation. It had an overall average for its procedures of about $6,000, but the average for individual procedures ranged from $1,000 to $12,000, a relatively wide spread of $11,000.

In itself, such wide variation would not affect equity if hospitals received a random distribution of patients within the range of expected treatment costs because losses on high-cost patients would tend to be offset by profits on low-cost patients.

However, we found that this did not happen.

The next chart I have shows the expected normal distribution of charges for all hospitals for DRG 442 and the distribution for hospital A. This chart illustrates a hospital that consistently treated patients who had lower-than-average treatment costs in DRG 442.

The procedures performed at this hospital in DRG 442 averaged about $2,800, compared with the national average for the DRG of about $6,000. The procedures at this hospital ranged in cost from about $1,800 to $5,700.

To assess whether the wide-variation DRGs were causing inequitable payments to hospitals, we first computed the national average cost of each procedure and diagnosis used to assign Medicare patients to each DRG. We call this the expected treatment cost of the diagnosis or procedure.

We used these national average costs in conjunction with the number of patients treated by each hospital to determine the hospital's average expected cost per DRG. This is the cost a hospital would have incurred if it were as efficient as the average hospital in the Nation.

We then compared this average cost with the amount the hospital would have received if it were paid based on the national average cost of the DRG. In effect, we compared what an efficient hospital's costs would have been to treat its patients with the amount it would have been paid. This analysis resulted in our finding that high and low expected treatment cost patients are not randomly distributed among hospitals. We concluded, therefore, that PPS rates for the wide-variation DRGs are not equitable.

Overall, we found that large urban hospitals tended to treat patients in the high-expected treatment cost end of the wide-variation DRGs. Small urban hospitals and rural hospitals tended to treat patients in the low end. For example, the next chart I have shows the experience of one urban hospital for DRG 12—a wide-variation DRG.

At this hospital, 100 of the 112 patients treated in DRG 12 had expected treatment costs that were higher than the national average treatment cost for the DRG—a difference of about $242,000. That is, even if this hospital were as efficient as the average hospital, it still would have lost $242,000 on its patients in DRG 12, or about $2,400 on each patient.

In contrast, the next chart I have shows that 92 of the 93 patients treated by one rural hospital in DRG 461—another wide-variation DRG—had expected treatment costs that were lower than the national average treatment cost for the DRG—a difference of about $137,000 below the national average. In essence, this hospital made about $1,400 on each patient it treated in that DRG, above what its expected costs were.

Two results are possible from such patterns. First, hospitals can profit or lose based on the mix of patients they receive rather than on their level of efficiency, as is supposed to occur under PPS. An inefficient hospital can profit if it treats primarily patients in the low end, but an efficient hospital can suffer a loss if it treats patients primarily in the high end.

Second, the wide-variation DRGs give hospitals a financial incentive to treat patients with low expected costs and avoid high-cost ones. This could eventually lead to access problems for some patients.

In our report, we are recommending that HHS take action to reduce the extent of variation in the 148 DRGs. We believe such action should help improve the equity of PPS payments.

Mr. Chairman, that concludes my statement, and we would be glad to answer any questions you may have.

[The statement of Mr. Michael Zimmerman follows:]

STATEMENT OF MICHAEL ZIMMERMAN, SENIOR ASSOCIATE DIRECTOR,
HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

We are pleased that you asked us to be here today to discuss the results of several studies we have done that looked at whether Medicare's hospital prospective payment system (PPS) rates are reasonable from the government's perspective and equitable from the hospital's perspective. First, we can tell you that the original PPS rates were too high because they were based on unaudited cost data that included substantial (1) unallowable costs and (2) costs for unnecessary services. Over the four subsequent annual updates, the PPS rates have been estimated and adjusted many times. Because of this, we do not know, nor do we believe anyone else really knows, whether the current PPS rates are reasonable in relation to "the costs of efficiently and economically providing covered services," the criteria for rates in the statute. We believe that the rates should be rebased by using current audited cost data that reflect hospital operations under PPS so everyone can see that relationship.

Second, because of the wide variation in treatment costs within many of the diagnosis related groups--DRGs--payments among hospitals may be inequitable. Our analysis showed wide variation in the costs of treating patients in about a third of the individual DRGs. Moreover, hospitals did not receive a random distribution of high and low expected cost patients in these wide-variation DRGs. Rather, certain types of hospitals consistently treated patients in the low end of the expected cost range, while other types consistently treated those in the high end. Thus, whether a hospital profits or loses for the wide-variation DRGs is a function of the hospital's mix of patients within those DRGs as well as its level of efficiency. The extent of intra-DRG variation should be reduced to improve the equity of PPS and to prevent giving hospitals perverse incentives to treat or not treat certain patients.

INITIAL PPS RATES TOO HIGH

When PPS began in fiscal year 1984, the initial rates were based on unaudited cost data and utilization data from fiscal year 1981. Between September 1983 and March 1986, we issued a series of reports discussing the inadequacies of these data bases and why their use inflated PPS rates. The first report[1] dealt with the unallowable costs and unnecessary services for inpatient respiratory therapy services included in the data bases. The second report[2] addressed the substantial percentage of unnecessary ancillary services included in the data bases. A third report[3] discussed the data base problems for cardiac pacemaker services. The fourth report[4] showed that using unaudited cost data inflated PPS rates by more than 4 percent.

---

[1] Need to Eliminate Payments for Unnecessary Hospital Ancillary Services, GAO/HRD-83-74, Sept. 30, 1983.

[2] Excessive Respiratory Therapy Cost and Utilization Data Used in Setting Medicare's Prospective Payment Rates, GAO/HRD-84-90, Sept. 28, 1984.

[3] Medicare's Policies and Prospective Payment Rates for Cardiac Pacemaker Surgeries Need Review and Revision, GAO/HRD-85-39, Feb. 26, 1985.

[4] Use of Unaudited Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates, GAO/HRD-85-74, July 18, 1985.

The fifth report[5] dealt with the high costs of unnecessary intensive care included in the data bases.

We recommended in March 1986 that HHS rebase PPS rates using cost data that reflect hospital behavior under PPS. HHS basically responded that it would study the problem. Rates have not been rebased, and we continue to believe they should be.

HOW ARE PPS RATES RELATED TO COSTS?

Since the establishment of PPS, rates have had four annual updates. These updates involved numerous adjustments that were designed to assure that the rates met the requirements of the statute to provide payments sufficient to cover the costs of efficiently and economically furnishing needed services. For example, adjustments were made to reflect changes in the overall mix of Medicare patients, improved hospital diagnosis coding, changes in technology and hospital treatment patterns, etc. These adjustments were often based on estimates and incomplete data. Thus, we do not know the relationship between PPS rates and the costs of efficiently furnishing services. But we do believe the government should know what that relationship is because it is vital to knowing whether rates are reasonable. The way to find out is to collect the current cost data necessary for rebasing.

Finally, much has been said over the last few years about hospital profit margins from their Medicare business. We were not surprised when hospital profits were reported as being high because, in our opinion, there was a lot of fat built into the PPS rate-setting data bases, and it should not have been difficult for hospitals to make a profit. We believe rebasing the rates would show how much of the fat has been cut out and would give the Congress a better understanding of the reasonableness of PPS rates.

ARE PPS RATES EQUITABLE?

In response to the question of whether PPS rates could be made more equitable, the short answer is yes. We are in the final stages of preparing a report on the equity of PPS rates as measured by intra-DRG variation in average treatment costs for the various diagnoses and procedures covered under individual DRGs.

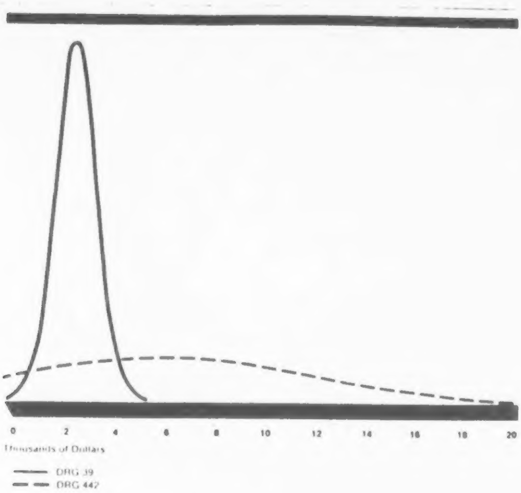
As you know, one of the primary goals of PPS is equitable payments to the hospitals that treat Medicare beneficiaries. To achieve this goal, it is important that the DRG case classification system accurately group patients with similar treatment costs. We measured the variation in treatment costs within each DRG and found that in 1985, this intra-DRG variation was at least 90 percent[6] for 148, or about a third, of the DRGs. Figure 1 shows the expected normal distribution of charges for two DRGs to illustrate the difference between a DRG with low variation in treatment costs and one with high variation.

---

[5] Medicare: Past Overuse of Intensive Care Services Inflates Hospital Payments, GAO/HRD-86-25, Mar. 7, 1986.

[6] The coefficient of variation was used to measure variation. It is a standard statistical technique and is the ratio of the standard deviation to the mean of a data set. This ratio is multiplied by 100 and expressed as a percentage--that is, the standard deviation as a percent of the mean.

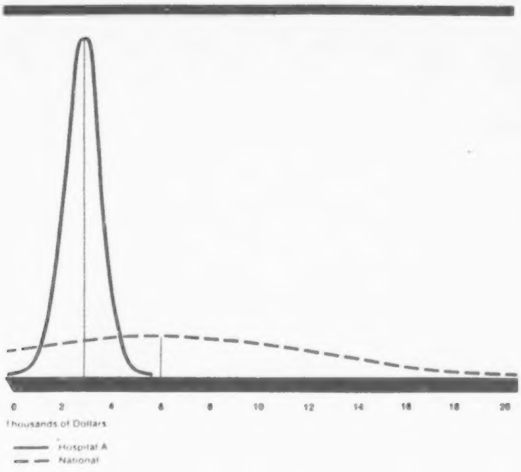
Figure 1: Expected Normal Distribution of Charges for DRG 39 and DRG 442 (Fiscal Year 1985)



As shown in the figure, DRG 39--a surgical DRG for eye diseases and disorders--had a low variation. This DRG had an overall average for all its procedures of $2,328, and individual procedures ranged from $2,009 to $2,499, a relatively narrow spread of $490. On the other hand, DRG 442--a surgical DRG for injuries--had a high variation. It had an overall average for its procedures of $6,046, but the average for individual procedures ranged from $1,012 to $11,948, a wide spread of almost $11,000.

In itself, such variation would not affect equity if hospitals received a random distribution of patients within the range of expected treatment costs because losses on high-cost patients would tend to be offset by profits on low-cost patients. However, we found that this did not happen. Figure 2 shows the national expected normal distribution of charges for DRG 442 and the distribution for hospital "A." The figure illustrates a hospital that consistently treated patients who had lower-than-average treatment costs in DRG 442.

Figure 2: Expected Normal Distribution of Charges for DRG 442, Nationally and for Hospital "A" (Fiscal Year 1985)



The procedures performed at this hospital in DRG 442 averaged $2,831, compared with the national average for the DRG of $6,046. Procedures at this hospital in DRG 442 ranged from $1,827 to $5,733.

To assess whether the wide-variation DRGs were causing inequitable payments to hospitals, we first computed the national average cost of each procedure and diagnosis used to assign Medicare patients to each DRG. We call this the expected treatment cost of the diagnosis or procedure. We used these national average diagnosis/procedure costs in conjunction with the number of patients treated by each hospital to determine the hospital's average expected cost per DRG. This is the cost a hospital would have incurred if it were as efficient as the average hospital in the nation. We then compared this average cost with the amount the hospital would have received if it were paid based on the national average cost of the DRG. In effect, we compared what an efficient hospital's costs would have been to treat its patients with the amount it would have been paid. This analysis resulted in our finding that high and low expected treatment cost patients are not randomly distributed among hospitals. We concluded, therefore, that PPS rates for the wide-variation DRGs are not equitable.

Overall, we found that large urban hospitals tended to treat patients in the high expected treatment cost end of the wide-variation DRGs. Small urban hospitals and rural hospitals tended to treat patients in the low end. For example, table 1 shows the experience of one large urban hospital for DRG 12--degenerative nervous system disorders--one of the wide-variation DRGs.

Table 1: Example of One Hospital's Expected Costs and Payments for Patients Treated in DRG 12 (Fiscal Year 1985)

	Number of patients	Expected total costs	Expected total payment	Profit or loss
Diagnosis costs less than DRG mean cost	12	$ 28,928	$ 38,241	$ 9,313
Diagnosis costs greater than DRG mean cost	100	570,449	318,655	(251,794)
Total	112	$599,377	$356,896	($242,481)

At this hospital, 100 of the 112 patients treated in DRG 12 had expected treatment costs that were higher than the national average treatment cost for the DRG--a difference of about $240,000 above the national average. That is, even if this hospital were as efficient as the average hospital, it would still have lost $240,000 on its patients in DRG 12.

In contrast, table 2 shows that 92 of the 93 patients treated by one rural hospital in DRG 461--another wide-variation DRG--had expected treatment costs that were lower than the national average treatment cost for the DRG--a difference of about $137,000 below the national average.

Table 2: Example of One Hospital's Expected Costs and Payments for Patients Treated in DRG 461 (Fiscal Year 1985)

	Number of patients	Expected total costs	Expected total payment	Profit or loss
Diagnosis costs less than DRG mean cost	92	$101,183	$238,470	$137,287
Diagnosis costs greater than DRG mean cost	1	2,731	2,592	(139)
Total	93	$103,914	$241,062	$137,148

Two results are possible from such patterns. First, hospitals can profit or lose based on the mix of patients they receive rather than on their level of efficiency as is supposed to occur under PPS. An inefficient hospital can profit if it treats primarily patients in the low end, but an efficient hospital can suffer a loss if it treats patients primarily in the high end.

Second, the wide-variation DRGs give hospitals a financial incentive to treat patients with low expected costs and avoid high cost ones. This could eventually lead to access problems for some patients.

We believe HHS should to take action to reduce the extent of variation in the wide-variation DRGs. Such action would help improve the equity of PPS payments.

This concludes my prepared statement; I will be happy to address any questions you may have.

Chairman **Stark**. Thanks, Mike.

I gather from your testimony that you think that we should rebase the PPS payments, and it is your feeling that HCFA hasn't studied it, and doesn't have the information to do it at this point; is that correct? As a matter of fact, are you saying that you don't think anybody really has the information?

Mr. **Zimmerman**. Well, I think the information becomes available when cost reporting information is reported out. I believe we have 1985 audited cost report data now; 1986 will probably be available this summer. I think either case is better than the 1981 unaudited data that were used to set the rates. And I personally feel a lot of the argument and debate seems to stem from just not having a decent understanding of what went into the system and where it stands today.

Chairman **Stark**. What do you think the overall impact would be on the hospital system?

Mr. **Zimmerman**. Well, I guess I would be joining the club of guessing with everybody else. I guess I have got a feeling that it would probably be pretty close to what we have now. I still think there would be some excessive costs reported across the board, but by and large, I think it would come pretty close to what the information is. But that is just speculation on my part.

Chairman **Stark**. But you do think it would smooth out differences in some of these reimbursements?

Mr. **Zimmerman**. I think it definitely would. You know the saying, "garbage in, garbage out." You know, we have got a $70 billion payment system, and we don't know its relationship to cost. And I find it a little difficult to deal with.

Chairman **Stark**. Do you want to chime in?

Mr. **Dowdal**. Yes. In the graphs we had up there, those charts, rebasing would not affect the intra-DRG variation because all diagnoses under DRG would still be paid the same rate. And each of those procedures has a vast difference in cost resulting in the wide-variation DRGs. Rebasing would help to make sure that the payment rate that is paid is set based on the reasonableness factor that is included in the Medicare law.

Chairman **Stark**. It is in your testimony that certain DRGs have huge, let's say excess, profits built into them, and other DRGs are almost losers to begin with.

Mr. **Zimmerman**. Well, I think it would be more of a situation as to which procedures within a DRG a hospital ended up treating, rather than the DRGs themselves. All DRGs are based on the average costs of the procedures within a DRG, and I don't know—maybe Mr. Davis knows how many procedures are in each DRG, but I think it could be as much as 50 or 100.

Mr. **Davis**. It varies.

Chairman **Stark**. I guess the follow-on is, in your opinion, could a hospital "game" the system? Many hospitals are running ads in newspapers and doing all kinds of things to promote business. Can a hospital, just through its marketing program, concentrate on just picking the DRG procedures which produce a lot of profit and kind of ignore or turn away the ones that do not?

Mr. **Zimmerman**. Well, we did this analysis on 5,000 hospitals for every DRG——

Chairman Stark. There are only 6,000 in the country.

Mr. Zimmerman. Well, we did it for 5,000 that are participating in the PPS system. We were able to do the analysis for every hospital and for every procedure and for every DRG. It would seem to me that a hospital ought to be able to do it, if it were so inclined, for itself, since we did it for everybody.

Chairman Stark. You did it for every hospital.

Mr. Zimmerman. We did it for every hospital.

Chairman Stark. So you have a data base available——

Mr. Zimmerman. That we could probably sell to every hospital if we wanted to.

Chairman Stark. How about letting us play with it here on the committee?

Mr. Zimmerman. We would be more than glad to, if you want to do that. We basically have it for every hospital in the country. Certain hospitals were excluded for various reasons, but by and large, we have them for almost every hospital.

Chairman Stark. Okay. But going back to that, did you——

Mr. Zimmerman. I guess I am saying yes, I think hospitals could pick and choose if they were so inclined. They would have to understand what their costs are for treating various procedures within a DRG or for various DRGs. How long they would be able to do that, that would be difficult to predict.

Chairman Stark. Did you want to add to that?

Mr. Davis. Yes. I think it is fair to add that by the same token, because there are not only low-cost patients or procedures within the DRG, but also very high-cost ones in some, that some hospitals by the way they are staffed or equipped—for example, hospitals with burn units and so on—are going to get patients not by their choice who are very costly to treat most of the time, also. I think that needs to be added, too.

Mr. Zimmerman. I think it is a question of picking and choosing. I mean, a hospital, if it wanted to, could be inclined to pick patients where it stands to profit extensively and also try to, if possible, avoid those patients in the high-cost procedures within a DRG where they stand to lose a substantial amount of money.

I might add we found no evidence that hospitals were doing that, but obviously, the potential is there, and that is the reason why we make the recommendation we make to HHS.

Chairman Stark. The American Hospital Association wants us to eliminate the payment differential between urban and rural hospitals. Do you think that would be a sound practice to start with, or only after we rebase?

Mr. Zimmerman. I think you have to rebase first to see what framework you are dealing with, and then obvious adjustments are going to have to be made for a variety of factors. But the base has to be straightened out first.

Chairman Stark. Do you think rebasing would take care of the large cost variation and the outliers? I mean, is rebasing really the panacea?

Mr. Zimmerman. No, I don't think so. Maybe Mr. Dowdal would want to comment on that point.

Mr. **Dowdal**. Rebasing, as I mentioned earlier, is for the accuracy of the payment for any DRG, all across the board, because that affects every DRG rate.

Chairman **Stark**. So rebasing will just allow us to more accurately assess our mistakes?

Mr. **Dowdal**. Right. So it gives you an idea of where payment rates really should be now, which we don't think anybody really knows because nobody has looked at it in that way.

Chairman **Stark**. Are you saying that nobody has looked at it because we are just kind of going along on 1981 data in 1988.

Mr. **Dowdal**. We have been tweaking the 1981 data for seven years now, and there have been so many adjustments made to it and so many guesses and so many estimates that I cannot——

Chairman **Stark**. Is it fair to say that the data were all built on cost reimbursement, and what you are suggesting is a different reaction institutionally to getting all your money back, as opposed to having to——

Mr. **Dowdal**. Not only was it built on cost reimbursement system data; it was built on bad cost reimbursement system data. It wasn't even the best data available for the cost reimbursement system.

The other issue on the DRGs, what you need there is if you have got 20 procedures under a particular DRG—and they range everywhere from $1,000 to $12,000—that is too wide a spread. You have to do something, modifying the mix of the procedures that you have covered under the DRG to get that into a more reasonable range of a couple thousand dollars or something. You can do that in a number of different ways—by splitting DRGs, recombining procedures between and among DRGs, and things like that.

Chairman **Stark**. One of the problems that we have legislatively is the industry itself and our own Department of Health and Human Services, a good example being the attempt a couple of years ago to push for payments under disproportionate share, as the law required. We just couldn't get the data. So, with the cooperation of the American Hospital Association, we just went ahead and built our own estimate on data that they provided.

Oftentimes, I think there is a reluctance—this is all a preamble to a question—for people to provide data for fear it will harm them rather than help them. So a familiar system is one that you learn to "game" or to compensate for, and rather than take your chances with a new system, the industry, the institution or the government tends to lock on and just kind of push for their own.

Can you see any legislative impetus that we could give to force the system, both HCFA and the industry, to revalue or to re-establish a data base, without destroying the whole system?

It seems to me that it is hard—we can ask for reports, and we can ask for all kinds of things—but it is easier to stall, as you are aware, than it is to go forward.

What direction could we take legislatively that would force the industry to rebase? Any ideas?

Mr. **Zimmerman**. Well, I think if you tie payment to coming forth with information somehow, then I think you will get full participation.

I have no ideas immediately, right now. I know you have asked us to look at the hospital cost reporting systems, the model HHS is supposed to come up with and do some comparative analysis for you.

The only way I can see getting industry to participate if there is a problem in this area is to tie it pretty close to the payment system. You don't get paid until you present a bill, or something to that effect.

Maybe Mr. Dowdal would want to add to that.

Mr. **Dowdal**. If you were specifically referring to rebasing, you can obviously put in the law—tell HHS it has to rebase by such and such a time. That was at one time in the Senate Finance reconciliation bill last year, I believe, or the year before. It can be done legislatively on the rebasing.

The one on the wide-variation DRGs is a little harder to do legislatively. That is something that is pretty much up to HHS that they are going to have to do.

Chairman **Stark**. Thank you.

Mr. Gradison?

Mr. **Gradison**. Thank you, Mr. Chairman.

Mr. Zimmerman, how long do you think it would take HCFA to develop data to correct the high-variance DRGs that these charts focus on—assuming they wanted to do it?

Mr. **Zimmerman**. I would think they might want to get some input from the hospital industry. I would say three to six months.

We have listed the DRGs. We have the information available for HHS that would show what the variation is by DRG. Obviously, they will have to think about how to group. As Mr. Dowdal mentioned, there are a couple ways of doing it. You could create new DRGs. We don't want to get into the game of having a DRG for each diagnoses, or we'll end up with 6,000 DRGs. So obviously, that would not make sense to do them all that way. But it will take some analysis.

HHS could start now. Some are more obvious than others. Some could probably be done immediately. I can sense their reluctance if, every time someone was not satisfied with how the DRG system was structured, they ran in and changed it. That could get to be a game in itself.

But I think it is not an insurmountable problem, and I think the information that we have that we will provide to you, HCFA, and HCFA's own ability to do analysis, I think they can move pretty quick on it.

Mr. **Gradison**. Are there any common elements in these high-variance DRGs, other than the numbers themselves? I mean, is there anything related to the nature of the procedure or the illness?

Mr. **Zimmerman**. Let me ask Mr. Davis to respond to that.

Mr. **Davis**. Yes, there were a couple things. Let me first say we didn't specifically look at the DRGs in that light. But there are a couple things that do stand out.

First of all, the data we used was '85 data, and at that time, the DRGs were structured along the lines where there were pairs of DRGs where the same diagnoses and procedures were in each pair, but one of the DRGs was for individuals who were older, age 70 and older, or who had certain complications and comorbidities.

Since that time, ProPAC has studied that issue and recommended that age be eliminated as a distinguishing factor for DRGs. So several of the DRGs which were included in our analysis fell into that category.

Second, there are a number of catch-all DRGs, if you will, that are in there, that are not designed along a specific body system where you would expect to have a certain similarity in resource requirements. For example, the DRG that we talk about up here, 442, is a surgical DRG for all types of injuries. Therefore, you have got procedures in there for eye injuries all the way to brain surgery. And those kinds of DRGs would make good targets to start looking at immediately to see how they could be perhaps broken up or restructured.

Mr. Dowdal. But overall, we cannot say that all the wide variation DRGs have a particular characteristic to them. There are both medical DRGs and surgical ones, and all of the different areas of the DRG system.

I think one of the reasons for the wide variation is that the origination of the DRG classification system at Yale University was primarily based on a clinical way of doing it. You group things together that were similar clinically. Now, often it worked out, and as we say in the report, for two-thirds of the DRGs it does not look like there is a big problem with variation. So a lot of times, it worked out. But sometimes, it just happened, I guess, that things that were pretty clinically similar, when you come down to the cost of the treatment, are not that similar.

Mr. Gradison. One final question. What is DRG 12 and what is DRG 461?

Mr. Zimmerman. It is in the report. Mr. Davis will look that up for you.

Mr. Dowdal. DRG 12, I think, is for degenerative nervous system diseases.

Mr. Davis. That's right. And 461 is one of those catchall surgical DRGs that I was referring to earlier.

Mr. Gradison. Surgical. I can see, then, that both of these by their very nature would have tremendous variation. It is very helpful to know that.

Mr. Davis. Right.

Mr. Gradison. Thank you very much.

Thank you, Mr. Chairman.

Chairman Stark. Mr. Coyne?

Mr. Coyne. Thank you, Mr. Chairman.

Mr. Zimmerman, GAO's statement that rural hospitals tend to treat lower than average cost patients would imply that rural hospitals should be making a large profit. This contradicts the information received by the subcommittee which indicates that rural hospitals have very low Medicare margins.

Could you explain that to us?

Mr. Zimmerman. Well, the lower than average expected cost patients treated by rural hospitals in the wide-variation DRGs is based on a national average for the diagnosis and procedures, rather than the hospitals' actual costs. Actual treatment costs in rural hospitals may in fact be higher than the national average, and this could be tied to the occupancy rate or other factors or problems that the rural hospitals are dealing with.

We don't necessarily see our information to be inconsistent with the fact that in reality, rural hospitals are not faring as well as this analysis would suggest.

Mr. COYNE. Thank you.

Chairman STARK. Thank you, Mike. As usual, you and your staff have ground through the numbers and provided us, unfortunately in this case, with a problem; I wish that we had the solution readily available. But I do look forward to working with you and your staff over this year to see if we can resolve the problems with the reporting procedures.

It seems to me that we do a disservice to the taxpayers for sure and probably inadvertently to many people in the hospital industry by working in the dark. I think that the data exists—it was in your testimony that you said it was no big deal to compile the data on 6,000 hospitals. Is that a fair statement?

Mr. ZIMMERMAN. Well, it wasn't as easy as I want to make it sound——

Chairman STARK. Your staff is looking at me like that was a stupid question.

Mr. ZIMMERMAN. I thought it was very easy; he didn't think so. [Laughter.]

But it can be done, and I think HCFA can do it much easier than we can.

Chairman STARK. Let me ask you this. Once you have the system in place, is it much of a problem to maintain it and disseminate it?

Mr. DAVIS. Yes, I'd have to say that's the key right there. Once you've got your system in place, and your programs and your analysis technique down, I think that that's half the battle.

Chairman STARK. Are the hospitals already providing in one form or another the raw data so that a decent system of cost reporting would not put tremendous extra burden on the hospitals? Are they already sending data that we can input into some other system and punch around?

Mr. DAVIS. Well, like any other reporting system, they are probably sending some data that is a burden to them to send, and it is not useful to us to use. On the other hand, there is other information that probably could be very useful that could take the place of some of that.

So probably, a system could be worked out without adding extra burden to anyone.

Chairman STARK. Thank you very much. I appreciate your testimony.

Our next witnesses will present a panel discussion. We welcome Dr. Gerald Anderson, director of the Center for Hospital Finance and Management and associate professor of health policy and management at Johns Hopkins University, who will join with Dr. Robert Rubin, the president of Health and Sciences Research, Inc.

I will call on you in the order in which you appear on our witness list.

Dr. Anderson, if you would like to begin. Both of you gentlemen have prepared testimony. You may amend that or expand on it or summarize it in any way that you are comfortable.

STATEMENT OF GERARD F. ANDERSON, PH.D., DIRECTOR, CENTER FOR HOSPITAL FINANCE AND MANAGEMENT, THE JOHNS HOPKINS MEDICAL INSTITUTIONS

Mr. **Anderson**. Thank you, Mr. Chairman.

My name is Dr. Gerard Anderson, and I appreciate the opportunity to testify this morning.

As I review the current status of the hospital industry, it appears that hospitals and physicians have taken two different approaches in responding to prospective payment specifically and payment reform more generally.

First, there have been significant changes, especially those involving medical practice. Length of stay has been reduced, and the use of outpatient surgery expanded. These changes have reduced costs without any apparent significant deterioration in overall quality of care or access to care.

In other areas, however, the medical community has decided to pursue a policy of "business as usual". For example, most hospitals have made few productivity gains in response to PPS.

In my testimony, I will concentrate on areas where hospitals could improve their productivity and raise an issue regarding hospital responses to payment reform which will require additional discussion in the coming years.

My analysis of hospital behavior since the passage of PPS suggests that hospital management has made few improvements in overall productivity. This behavior is not altogether surprising. Most studies of profitmaking corporations suggest that managerial practices are resistant to change unless there are significant outside forces requiring that change. Generally, this requires a sustained operating loss which threatens the survival of the corporation.

In the hospital industry, payment reform has not endangered the survival of most hospitals. In fact, operating margins have been higher in recent years than ever before. As Dr. Altman suggested earlier, operating margins are now returning to pre-PPS levels and are certainly way above the operating margins in the late 1970s.

During this period, hospital costs per admission have continued to increase at the same rate as before PPS was passed, suggesting that hospitals have not changed their operating behavior. It is important to remember that hospital costs are starting from a base where hospitals were generally believed to be inefficient because they lacked any financial incentive to be efficient. As a result, their inability to lower the rate of increase in hospital costs is somewhat surprising.

Since PPS was adopted, a number of indicators suggest that the hospital industry has done little to improve efficiency and in fact may have actually taken actions which will increase overall costs. Between 1983 and 1987, the number of inpatient days declined by 17 percent. During this same period, the number of staff beds declined by only 0.4 percent, and full-time equivalent personnel was reduced by only 3 percent. Clearly, hospitals have not responded to the changing market conditions by reducing their size or their staffing.

By the end of 1987, less than 63 percent of the hospital beds were occupied. In 1986, 41 percent of all hospitals were operating at less than 50 percent occupancy, and 57 percent were operating at less than 60 percent occupancy. Rural hospitals had even lower occupancy rates—over half were operating at less than 50 percent occupancy.

Most studies suggest a very strong correlation between negative profit margins and low occupancy rates. As a result, administrators at these hospitals need to review their capital needs and their staffing patterns in order to remain efficient.

At the same time that occupancy rates are declining, many hospitals are undertaking major new capital construction projects. Since 1981, the percent of hospital expenditures devoted to capital has grown each year. In 1981, hospitals spent 7 percent of their overall budget on capital. By 1986, the percentage had grown to over 9 percent. In the Medicare program, capital spending increased 10 percent per year in 1986 and at the same rate in 1987—a rate much faster than the PPS update factor or other Medicare pass-through amounts. Spending on capital projects is traditionally a way for organizations to spend excess revenues.

Both the number of personnel per bed and the amount of capital per bed has increased since the passage of PPS, while the number of patients treated has declined substantially. This suggests lower hospital productivity since the passage of PPS. This suggest to me that hospital costs are following hospital revenues, or in other words, hospitals are spending what they receive.

These capital projects have major financial implications for individual hospitals. The University of Michigan hospital recently completed a $460 million renovation of their facility. The debt service and interest payments alone increased the average cost per discharge by 5 to 10 percent, or between $200 and $400 per discharge. In the long run, this capital project will also increase operating expenditures probably by between 10 and 20 percent per year. While this is one of the largest capital investment in recent years made by hospitals, studies that we have done at the Center for Hospital Finance and Management for ProPAC suggest that many other hospitals are making similar investments which have similar long run financial consequences.

Now let me turn to a gray area which is more philosophical and involves less data. It involves medical practice and payment reforms, which I believe was going to be an increasingly important issue for you to debate in the next several years.

This involves medical practice which can improve the quality of care, but at a significant increase in cost. The question is going to be whether the added benefits are worth the increased costs.

At the Center for Hospital Finance and Management, we are studying a new technology which illustrates the difficult cost/quality tradeoffs that payment reform has created for hospitals and clinicians. This example illustrates the types of questions that PPS has raised on an operational level.

We are studying contrast media—a dye used by radiologists to visualize certain parts of the body. The issue is whether to continue to use the conventional contrast media which has some side effects or to adopt the new contrast media which is between 10 and 20 times more expensive but has fewer side effects. The diagnostic capabilities of both the old and the new media are exactly the same.

At the Johns Hopkins Hospital, the cost of changing to the more expensive media would be approximately $2 million per year, or the equivalent of purchasing a new magnetic resonance imager each year. There is some evidence of lower major side effects, such as fatal allergic reactions, but the probabilities are so low and the number of adverse occurrences are so small, that in fact there may be no statistically significant differences between the two media.

The evidence is quite strong, however, that the more expensive media will result in a lower probability of having minor side effects such as vomiting or pain upon injection. The question becomes: Is this benefit worth the added cost—the additional $2 million which Johns Hopkins would have to spend.

Currently, most hospitals are restricting the use of the more expensive media to certain patients thought to be at high risk for adverse reactions. However, if cost were not a factor, then the more expensive media likely would be used in all patients.

The diffusion rate of this new contrast media raises questions about whether we in the United States want the best available medical care regardless of the cost, or whether we are prepared to forego certain potential improvements in care because we do not believe the improvements are worth their added cost. It also raises questions of whether Medicare beneficiaries should be able to purchase the more expensive media by paying for the higher cost out of their own pocket if hospitals choose not to offer it. As Medicare continues to control PPS rates, these types of questions will begin to occur with increasing frequency.

I would be glad to answer any questions you may have.

[The statement of Gerard F. Anderson follows:]

THE CENTER FOR HOSPITAL FINANCE AND MANAGEMENT
THE JOHNS HOPKINS MEDICAL INSTITUTIONS

624 North Broadway Baltimore, Maryland 21205 (301) 955-2300

My name is Dr. Gerard Anderson. I am the Director of the Center for Hospital Finance and Management, Co-Director for the Program of Medical Technology and Practice Assessment, and Associate Professor of Health Policy and Management at Johns Hopkins University. I appreciate the opportunity to testify this morning.

As I review the current status of the hospital industry, it appears that hospitals and physicians have taken two different approaches in responding to Prospective Payment specifically and payment reform generally. Hospitals have made significant changes especially those involving medical practice. Length of stay has been reduced and outpatient surgery expanded. In other areas the medical community has decided to pursue a policy of business as usual. For example, most hospitals have made have made few productivity gains in response to PPS. In my testimony I will amplify these two points and raise an issue involving hospital responses to payment reform which will require additional analysis in the coming years.

Improvements in Medical Care

Hospitals and physicians have made a number of changes in medical practice which can be associated with Prospective Payment and other payment reforms. Probably the most significant change for the Medicare program is a reduction in the average length of stay. In 1983, before the passage of PPS, it was generally believed that Medicare patients remained in the hospital too long because of the economic incentives created by cost based reimbursement. From 1983 to 1984 the average length of stay in the Medicare program dropped by more than one day, and has remained relatively stable in recent years. This initial reduction in length of stay resulted in significant cost savings and is partially responsible for the sizeable profit margins enjoyed by hospitals during the initial years of PPS.

Preliminary evidence suggests that shorter lengths of stay may be a problem for Medicare patients not because patients are being discharged prematurely but because the they do not have sufficient access to the social and medical services they need after they are discharged from the hospital. I am directing a study examining post discharge outcomes of elderly patients sponsored by the Retirement Research Foundation. Our preliminary findings suggest that Medicare patients within 120 days of discharge have a number of serious unmet medical and social needs which are not addressed by existing public and private programs.

In addition, the medical community has responded to the change in economic incentives by substituting more outpatient surgery for inpatient surgery. For example, cataract surgery was the third most common impatient DRG in 1984 and was not even in the in the top 50 DRGs by 1986 because of a shift to ambulatory surgery.

No Productivity Gains

While there have been significant changes in response to payment reform, hospital management has made few improvements in recent years. This behavior is not surprising. Most studies of profit making corporations suggest that managerial practices are resistant to change unless there are significant outside forces requiring that change. Generally this requires a sustained operating loss or a takeover attempt which threatens the survival of the corporation. Only after the corporation is threatened will most organizations undertake fundamental changes such as reducing personnel or changing their capital structure.

In the hospital industry, payment reform has not endangered the survival of most hospitals. In fact, operating margins/profit margins have been higher in recent years than ever before. Margins are now returning to pre PPS levels.

During this period hospital costs per admission have continued to increase at the same rate as before PPS was passed, suggesting that hospitals have not changed their operating behavior. It is important to remember that hospital costs are starting from a base where hospitals were generally believed to be inefficient because they lacked any financial incentive to be efficient. In fact, prior to PPS, Medicare and other payment systems included incentives for them to increase costs as much as ossible. As a result, their inability to lower the rate of increase in costs is somewhat surprising.

Since PPS was adopted, a number of indicators suggest that the hospital industry has done little to promote efficiency and n fact may have actually taken actions which will increase overall costs. Between 1983 and 1987 the number of inpatient days declined by 17 percent. During this same period, the number of staffed beds declined by only 0.4 percent and full time equivalent personnel was reduced by only 3 percent. Clearly hospitals have not responded to the changing market conditions by reducing their size.

At the end of 1987, less than 63 percent of the hospital beds were occupied. In 1986, 41 percent of all hospitals were operating at less than 50 percent occupancy and 57 percent were operating at less than 60 percent occupancy. Rural hospitals had even lower occupancy rates - over half were operating at less than 50 percent occupancy. Most studies suggest a strong correlation between negative profit margins and low occupancy rates. Administrations at these hospitals need to review their capital needs in order to become more efficient. Operating at these low occupancy rates means that the fixed costs of capital consume an unnecessarily large proportion of the hospitals budget. If the hospital is staffed to fill these beds, then the cost and efficiency loss is even greater. The relatively small reduction in staffing from 1983 to 1987 suggests that the beds are over staffed.

At the same time that occupancy rates are declining, many hospitals are undertaking major new capital construction projects. Since 1981, the percent of hospital expenditures devoted to capital has grown each year. In 1981, hospitals spent 7 percent of their overall budget on capital. By 1986, the percentage had grown to over 9 percent. In the Medicare program spending on capital increased 10 percent per year in 1986 and again in the first half of 1987 - a rate much faster than the PPS update factor or other Medicare pass thru amounts. Spending on capital projects is traditionally a way for organizations to spend excess revenues. It suggests that hospital costs follow hospital revenues, or in other words, hospitals spend what they receive.

These capital projects have major financial implications for individual hospitals. The University of Michigan hospital recently completed a $460 million expansion/renovation of their facility. The debt service and interest payments alone increased the average cost per discharge by 5-10 percent or between 200 and 400 dollars. In the long run, this capital project will probably increase operating expenditures by 10 to 20 percent as well. While this is one of the largest capital investments in recent years, studies we have done at the Center for Hospital Finance and Management for ProPAC suggest that many other hospitals are making similar investments.

A Gray Area

I have presented areas where hospitals and physicians have lowered costs without significantly affecting quality of care and areas where they have made a few productivity gains. There is also a third area where the cost/quality tradeoffs are much less clear and warrant further study by all interested parties. This involves medical practice which can improve quality of care but at a significant increase in cost. The question is whether the added benefits are worth the increased cost.

At the Center for Hospital Finance and Management we are studying a new technology which illustrates the difficult cost/quality tradeoffs that payment reform has created for hospitals and clinicians. We are studying contrast media - a dye which is used by radiologists to visualize certain parts of the body. The issue is whether to continue to use the conventional contrast media which has some side effects or to adopt the new contrast media which is 10-20 times more expensive but has fewer side effects. The diagnostic capabilities of both the old and the new media are exactly the same.

At The Johns Hopkins Hospital, the cost of changing to the new more expensive media would be approximately $2 million per year or the equivalent of purchasing a new magnetic resonance imager each year. There is some evidence that the probability of major side effects, such as fatal allergic reactions are lower in the more expensive media, but the probabilities are so low and the number of adverse occurrences so small, that there may be no statistically significant difference between the two medias. The evidence is quite strong, however, that the more expensive media will result in a lower probability of having "minor" side effects such as vomiting or pain upon injection. The question is whether this benefit is worth the added cost. Currently, most hospitals are restricting the use of the more expensive media to certain patients thought to be at high risk for adverse reactions. However, if cost were not a factor, then the more expensive media likely would be used in all patients. The diffusion rate of this new contrast media raises questions about whether we, in the United States, want the best available care regardless of the cost required to achieve it, or whether we are prepared to forego certain potential improvements in care because we do not believe the improvements are worth their added cost. It will also raise questions of whether Medicare beneficiaries should be able to purchase the more expensive media by paying for the higher cost out of their own pocket. As Medicare continues to control PPS rates, these types of questions will begin to occur with increasing frequency.

Summary

Hospitals and physicians have made great progress in controlling costs without sacrificing quality. The reduction in the length of stay and move to outpatient surgery are good examples of changes which have lowered costs without sacrificing quality of care or access to care.

At the same time, there are also areas where hospitals have done very little. Primarily these involve changes in hospital management - hospitals have not learned how to use capital or personnel to improve productivity - in fact, productivity may have declined in the last several years.

Finally, there are areas where hospitals and clinicians need guidance on the appropriate cost/quality tradeoffs. Simply stating that Medicare pays a price for a given DRG and the hospital and clinicians make their own judgments about appropriate medical care ignores the very important role that revenue constraints play on hospital decision making.

Chairman STARK. Thank you, Dr. Anderson.

We will ask Dr. Rubin to present his testimony, and then we the committee will inquire of both of you gentlemen.

Welcome to the committee, Dr. Rubin. Please proceed.

STATEMENT OF ROBERT J. RUBIN, M.D., PRESIDENT, HEALTH AND SCIENCES RESEARCH INCORPORATED

Dr. RUBIN. Thank you.

I'd like to briefly summarize my testimony and have my entire statement, if you will, included in the record.

Chairman STARK. Without objection.

Dr. RUBIN. My name is Robert Rubin. I am currently a clinical associate professor of medicine at Georgetown University, as well as the president of Health and Sciences Research Incorporated, a Washington-based consulting firm.

I last testified before this committee in my former capacity as Assistant Secretary for Planning and Evaluation during the first 3 years of the Reagan administration. At that time, I was chairman of the intra- and inter-departmental task forces charged with the design, implementation and trying to achieve passage of the prospective payment legislation.

I am appearing here this morning at the request of the committee rather than representing any of our clients. The studies I will be referring to, however, were done for a variety of clients, including but not limited to the Department of Health and Human Services, the Department of Defense, the National Committee for Quality Health Care, and a variety of hospital groups, systems, and associations.

Prior to implementation of the Medicare prospective payment system, most payers reimbursed hospitals based upon the actual cost of providing services to Medicare beneficiaries. Recognized costs included operating capital and teaching-related expenses. In theory, for every dollar spent on a Medicare patient, a hospital was paid a dollar.

Because this system created no incentives to control cost, we designed, you passed, and we implemented prospective payment. This system created strong incentives to control costs. In addition, for the first time, Medicare allowed hospitals to be rewarded for becoming more efficient.

The first year of prospective payment resulted in a reduction in the rate of increase in Medicare expenditures. Medicare length of stay declined. Medicare margins also, predictably, increased.

In other words, for each dollar spent on a Medicare patient, the average hospital made more than a dollar.

Payment to most hospitals under PPS is currently determined by the national standardized amount. This standardized amount was determined in 1983, using 1981 data, and has been inflated each year to set the current year payments. The inflation factor, as originally designed, was supposed to reflect the increase in the inputs to hospital services, as well as an additional amount to reflect advances in technology and also in productivity.

In fact, the standardized amount has been inflated by far less. Between 1985 and 1988, for example, the increase in the hospital market basket is estimated to have been about 11.5 percent. The standardized payment amount has gone up by much less.

The result of all of this is that in 1988, it has been estimated that the average hospital will be paid less than one dollar for every dollar spent on a Medicare beneficiary.

These estimates have been made not only by provider groups, but by researchers within the Government and, as you heard earlier, by the Prospective Payment Assessment Commission.

This will be true for almost one-half of our community hospitals. Hospitals estimated to be experiencing negative margins seem to be similar to all other hospitals. You cannot look at these hospitals and say they have low occupancy or high employee-to-bed ratio. Because Medicare represents a large portion of hospital revenues, negative margins have a strong impact on the overall financial health of our hospitals.

Not only have Medicare margins declined, but for the past two years, overall hospital margins have declined as well. Negative margins can be made positive either by increasing revenues or decreasing costs. Therefore, the critical question is whether hospitals can further reduce costs without affecting the quality of care provided to Medicare patients and indeed to all of their patients.

Looking at the current situation, the answer appears to be: No.

Labor costs represent a major controllable portion of hospital expenditures, and nursing salaries represent a large part of labor expenses. All of the evidence suggests that hospitals will have to increase the number of nurses employed and the salaries they are paid.

This is true because medical advances require more nurses per patient, as Professor Altman testified earlier. And indeed, the numbers that he cited are well-known to those of us who go to the hospital on a daily basis.

However, it is useful to take a look at what happened in 1979, when we also had a nursing shortage. Wages were then increased by 13 percent, and literally within a year and a half, nursing vacancy rates fell to almost nothing.

Yet in today's environment with curtailed payments, it is unlikely that wages will rise enough to reduce the shortage. Indeed, in 1986, nursing salaries increased only 4 percent.

In what other ways can hospitals respond? Well, they can first, continue to discharge patients more quickly, shifting costs to nursing homes and home health agencies. That helps hospitals, but certainly not society. Second, they can reduce the level of services provided to the severely ill—a result nobody wants. Third, they can close unprofitable units, such as critical care units or burn care units. Or finally, fourth, they can close entire hospitals.

All of these things could result in less money being spent on Medicare patients and may even achieve some budget savings. They may also result in a lower quality of care being provided to Medicare beneficiaries or in reduced access to care. For example, many people have argued that any system which results in excess hospital beds being closed is a good one. However, the hospitals that appear in greatest danger of closing are rural hospitals and inner-city urban hospitals—rural hospitals, which serve as the primary source of basic health care in rural communities, as well as frequently being the major employer in that community; and inner-city urban hospitals, or public hospitals, which provide a large amount of our charity care, a major portion of the medical professional training in our country, and are an important source of care for AIDS patients.

These are clearly not the hospitals we want closed. It appears that the current system may not be able to discriminate between excess supply and needed services.

If these trends continue, the health care system, Medicare beneficiaries, and all Americans will be in serious jeopardy. Access to care will be severely restricted, particularly for Americans living in rural areas. Hospitals that serve the most vulnerable among us would likewise be affected first. The training of our next generation of physicians would be severely impacted.

It would be easy to conclude that what our health care system needs is more money. That conclusion would by itself be wrong. We must, of course, remove fraud, waste, and abuse from our health care delivery system. I doubt, however, that this will be sufficient.

We must also commit ourselves to providing adequate funding for our health care providers rather than viewing public programs as a vehicle for solving budget deficits.

Thank you very much.

[The statement of Dr. Robert J. Rubin follows:]

TESTIMONY

ROBERT J. RUBIN, M.D.

SUBCOMMITTEE ON HEALTH
HOUSE WAYS AND MEANS COMMITTEE

MARCH 1, 1988

My name is Robert J. Rubin, M.D. I am currently a clinical associate professor of medicine at Georgetown University as well as the president of Health and Sciences Research Incorporated (HSRI), a Washington based consulting firm. I last testified before this committee in my former capacity as Assistant Secretary for Planning and Evaluation during the first three years of the Reagan administration.

I am appearing here this morning at the request of the committee rather than representing any of our clients. The studies I will be referring to, however, were done for a variety of clients including but not limited to, the Department of Health and Human Services (HHS), the Defense Department (DoD), the National Committee for Quality Health Care and a variety of hospital groups, systems and associations.

Historically, most payers, including government payers, reimbursed hospitals based on the costs of providing services. For example, the Medicare program reimbursed hospitals for the costs of providing care to Medicare beneficiaries. The costs included reimbursement for operating expenses, capital expenses, and any costs associated with teaching programs. Medicare also covered any bad debt associated with its beneficiaries. Other payers paid hospitals based on charges, or reduced charges. Still others negotiated discounts that were based on the hospital's charges. Because all of these systems ensured that patient care expenses would be fully paid, facilities had no incentive to control the increase in costs associated with patient care.

Since the early 1980s, most payers have developed alternative systems, which provide stronger incentives to control costs. Medicare, the largest single purchaser of hospital care, accounting for 29 percent of all hospital revenue in 1986, currently pays hospitals a flat amount for each admission.[1] This amount is adjusted for diagnosis and for several other hospital-specific features, such as whether the hospital is a teaching hospital or serves a large percentage of indigent and uninsured patients. This prospectively based system allows hospitals to determine, in advance, their payment for providing inpatient care to Medicare beneficiaries. Medicare pays additional hospital costs associated with capital expenses and the direct costs of teaching programs.

This system is updated annually by increasing the payment amount per discharge (called the standardized amount) and by recalculating the weights applied to adjust this amount for an individual's diagnosis (called the DRG weights). Each year Congress and the Health Care Financing Administration (HCFA) attempt to determine the appropriate inflation update amount (inflator) using information on hospital cost increases. Although the inflator used for the standardized amount was originally intended to reflect the increase in hospital costs each year, in recent years it has been much lower than the actual increase in hospital expenses. The growth in hospital expenses, therefore, has been more rapid than the increase in revenues. Consequently, hospital net income from Medicare has declined substantially. In fact, it is estimated that in 1988, over 40 percent of the Nation's community hospitals may have a negative net income for Medicare patients.[2]

---

[1] Division of Cost Estimates, Office of the Actuary, Health Care Financing Administration, "National Health Expenditures, 1986-2000," Health Care Financing Review 8(4):1-36, Summer 1987.

[2] ICF analysis of HCFA data.

Even more troubling than the large percentage of hospitals with negative margins is that the characteristics of hospitals with negative margins are not substantially different from all hospitals. You can't look at these hospitals and say that they have uniformly low occupancy or high employee to bed ratios. However, on average, these hospitals are being reimbursed 90 cents for every dollar they *spend* on a Medicare patient. Because Medicare represents a significant portion of a hospital's costs, this has a strong negative impact on hospitals' financial condition.

What is the Impact of these Changes?

New reimbursement systems have resulted in a dramatic change in hospital behavior. Systems which limit payments to hospitals create strong incentives to cut costs by improving efficiency. Increased efficiency can result in better care or increased levels of care at lower cost or both. Alternatively, as reimbursement becomes less than the actual costs of providing care, the level of care may be reduced.

Under these systems, hospitals have incentives to:

- *Discharge patients earlier*--Hospitals have an incentive, under a price based system, to discharge patients "sicker and quicker". Because a hospital is paid the same amount for a Medicare patient regardless of the length of time spent in the hospital, the hospital can reduce its costs by discharging the patient quickly. This is true for any other discharge-based payment system. Patients may be discharged either to nursing homes, to home health care, or to self care. In most cases, this results in health care in a more appropriate setting. In some cases, however, a discharge to another setting may not be in the patient's best interest. In fact, Medicare average length of stay per hospitalization declined from 10.7 days to 8.4 days from 1979 to 1985, although not all of this can be attributed to the new payment system.[3] Length of stay for all patients also dropped by six percent over the same period.

- *Reduce levels of care to the severely ill*--Hospitals also have an incentive to reduce admissions of severely ill patients who require a greater number of services and are, therefore, more expensive to care for. They also have an incentive to reduce the number and intensity of services to severely ill patients in an effort to reduce costs. Specialty hospitals or hospital units that generally treat severely ill patients may be at a disadvantage, unless exceptions are made in reimbursing these units. For example, there are 135 hospitals across the U.S. with units that treat patients with severe burns. These units provide highly specialized care, saving lives which might not be saved otherwise, but the cost of providing this treatment is enormous and is not adequately reflected in the current Medicare payment system. As a result, in 1984 burn centers received only 44 percent of the costs of treating Medicare burn patients.[4]

- *Hospitals have increased incentives to provide services in outpatient settings*--Most of the new payment systems have been limited to inpatient services. Services provided on an outpatient basis are frequently reimbursed based on incurred costs. This has led to tremendous growth in the number of hospital outpatient surgical facilities and freestanding surgical centers. Many payers, including Medicare, however, are developing payment restrictions on outpatient services as well.

There is little doubt that hospitals have been hurt by changes in reimbursement. Hospital margins have very recently begun to decline, and there is no evidence to suggest that they will increase in the near future. This has resulted in hospital closures. Many people would argue that we have an oversupply of hospital beds and that bed closures are desirable. But, the current system may not be able to discriminate between excess supply and needed facilities. As a consequence, the availability of services to particular populations or geographic areas may be jeopardized.

---

[3] Stuart Guterman and Allen Dobson, "Impact of Prospective Payment System for Hospitals," *Health Care Financing Review* 7(3):97-114, Spring 1986.

[4] ICF Analysis of 1984 MEDPAR data.

What are the Implications for the Future?

Hospital Closures

It has been estimated that 40 percent of all hospitals will be closed or converted to other purposes by the year 2000.[5] Hospital closures of this magnitude are likely to result in an undersupply of services. In order to understand what this means for the future, we must identify the types of hospitals likely to close.

Two hospital groups have been particularly affected by recent changes in reimbursement: public hospitals and rural hospitals. Public hospitals are hospitals generally owned or operated by a city or county government. They can also be associated with a state university or hospital district. These hospitals are generally located in a large urban area and usually depend, to a large extent, on public funds to support their activities. Public hospitals are unique as one of the only hospital groups to experience an increase in average occupancy since 1980. In 1985, their average occupancy rate was 80 percent compared to 65 percent for all hospitals.

They are also unique because almost 30 percent of their net revenues are from state and local appropriations and because they provide much of the charity care in many areas. For example, a study in Georgia found that, while public hospitals accounted for only 14 percent of the beds in the state, they accounted for 44 percent of the free care.[6]

The future of public hospitals is uncertain. In 1982, it was estimated that 50 percent of these hospitals operated at a loss, compared to 22 percent of not-for-profit hospitals. The proportion of their gross revenues from Medicare and from government sources has actually declined since 1983, and the proportion from Medicaid and private insurers has remained constant. This suggests that these hospitals have experienced an increase in bad debt and charity care demands. In other words, they are providing an increasing amount of health care that is not paid for. The average age of the physical plant of these hospitals has also increased because capital is not readily available to support new construction, renovation or the addition of new technology. Finally, public hospitals have been disproportionately affected by the AIDS epidemic. In a recent survey, public hospitals, representing 25 percent of the hospitals in the survey, provided 53 percent of the AIDS patient days. All of these factors indicate that, unless there are changes, it is likely that the financial condition of these hospitals will worsen, and the likelihood of closure will increase. In fact, in the last ten years, seven of these hospitals have closed and an additional ten have been sold, leased, or reorganized.

The closure of public hospitals would severely limit access to health care for the uninsured poor. Researchers recently compared the volume of care provided to the uninsured in 99 of the 100 largest U.S. cities. They found that cities with public hospitals provided care to a larger percentage of the uninsured poor than cities with no public hospitals (31-34 adjusted admissions per 100 uninsured poor compared to 24 adjusted admissions). These results indicate that public hospitals not only reduce the burden on private hospitals, but also actually increase access for the uninsured poor.[7] In addition, certain specialized services, such as burn care, neonatal care and psychiatric care are more likely to be offered at these hospitals. Finally, these hospitals train about 12 percent of the physicians educated in this country. Closing public hospitals, therefore, would reduce the volume of uncompensated care provided in the communities in which they are located, it would reduce access to certain types of specialized care and it would reduce the number of facilities available for physician training.

---

[5] Larry S. Gage, Dennis P. Andrulis, and Virginia Beers, America's Safety Net: A Report on the Situation in Our Nation's Metropolitan Areas (National Association of Public Hospitals, October 1987).

[6] Ibid.

[7] Kenneth E. Thorpe and Charles Brecher, "Improved Access to Care for the Uninsured Poor in Large Cities: Do Public Hospitals Make a Difference?" Journal of Health, Politics, Policy and Law 12(2):313-324, Summer 1987.

If public hospitals close, or reduce the levels of charity care provided, there will be increased pressure on non-teaching hospitals located in the same urban areas to provide these services. These hospitals currently do not provide the types of specialized services frequently available in teaching institutions. They do, however, provide high quality services of the type most frequently demanded by the populations they serve. These institutions are experiencing declining margins and will not be able to finance increased levels of charity care. In fact, because of declining margins, these hospitals have not been able to invest in new plant and equipment, and, as a result, the age of their plant has increased to an all time high of 7.3 years.[8] In addition, these hospitals are experiencing the same difficulties attracting staff, including nurses and physical therapists, as other hospitals. Closing public hospitals, therefore, would add to their already worsening financial situation.

Rural hospitals are the second group of hospitals for which the future is uncertain. Rural hospitals differ markedly from urban hospitals. For example, although they account for 48 percent of all hospitals, they account for only 21 percent of the beds, averaging 76 beds per facility, as compared to 252 for urban hospitals. They also account for only 24 percent of the Medicare discharges and have an average length of stay that is two days shorter than urban hospitals.[9] The rural hospital may be one of the largest area employers, as well as the only source of health care for a community. In fact, 363 rural hospitals have been designated sole community providers by the Health Care Financing Administration (HCFA).

Several factors have created special problems for rural hospitals. First, occupancy has fallen substantially due to fewer admissions and shorter length of stay. This decline has not been confined to rural hospitals, but has a much greater impact on their operation. Occupancy in rural hospitals with less than 25 beds has declined by 28 percent since 1980, while rural hospitals with between 25 and 50 beds have experienced a decline of 14 percent. This compares to a decline of 6 percent for all hospitals over the same period.[10]

Second, demographics have slowed the growth in the population served by rural hospitals, while increasing the average age of the rural population. In addition, a general economic decline in rural areas has both reduced the resources available to pay for health care services and limited the ability of local communities to support their hospitals through the tax base.

Third, rural hospitals are increasingly competing with urban hospitals that are reaching out to rural areas to expand their market share. While this may increase the availability of some services to the local community, it may threaten the viability of local hospitals, which may offer a different range of services.

Finally, under Medicare, rural hospitals are paid a different standardized amount, which in FY 1987 was 20 percent lower than the urban standardized amount. This difference exists because historically the costs associated with treatment of Medicare patients in rural hospitals have been lower than in urban hospitals. As a result, rural hospitals generally have a lower Medicare operating margin and may have more difficulty getting the capital necessary to renovate or invest in new types of technology. The acquisition of new technologies and the latest in medical developments is critical if they are to compete effectively with urban hospitals and if they are to provide the best health care to residents of the local community.

---

[8] Healthcare Financial Management Association, Hospital Industry Financial Report, 1982-1986, September 1987.

[9] James E. Hatten and Rose E. Connerton, "Urban and Rural Hospitals: How do they Differ?" Health Care Financing Review 8(2):77-85, Winter 1986.

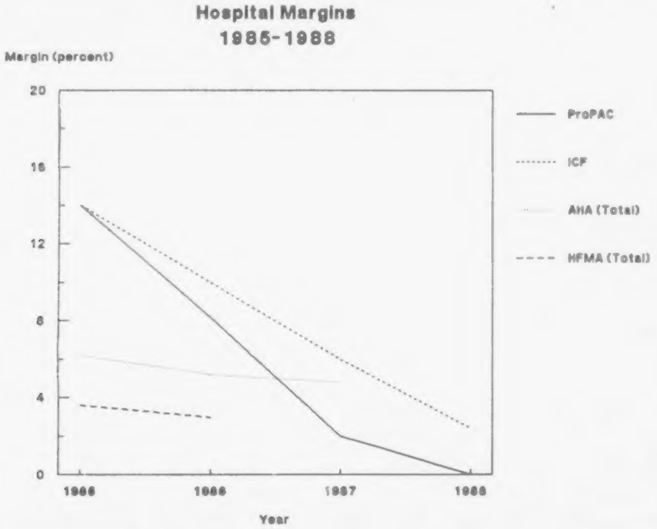
[10] Prospective Payment Assessment Commission, Technical Appendixes to the Report and Recommendations to the Secretary, U.S. Department of Health and Human Services, April 1987, p. 96.

Rural hospital closures may mean that people have to travel substantial distances to receive health care. Since 1980, 86 acute care hospitals have closed in rural areas. Most were hospitals with fewer than 50 beds. These hospitals were located in 85 counties, and in six cases the hospital that closed was the only one in the county.[11] Closure of the community hospital can have a greater impact on the local community than just the loss of health services. Since the hospital is a major employer in many cases, it could disrupt the local economy. Furthermore, it may limit the community's ability to attract other health professionals, especially physicians. This can limit access to basic health care services, in addition to inpatient hospital services.

For example, when Cottle County Hospital in Paducah, Texas closed, local residents were forced to drive more than 50 miles to the nearest hospital. Efforts to replace the town's only physician have failed, so that with his retirement, there will be no physician in this town of 2,200 people. This hospital closed despite a tax increase for its support voted earlier by local residents.

The impact of rural hospital closures will be felt disproportionately by certain states. In 1984, there were ten states where rural hospitals represented more than 85 percent of the state's hospitals.[12] As a result, people in these states may be confronted with substantially reduced access to care.

The critical question is whether Medicare's PPS is providing adequate payments to hospitals. Looking at the current situation, the answer is clearly - NO. PROPAC, the Inspector General of HHS, as well as other divisions of HHS have all confirmed the precipitous drop in hospital margins. While the hospitals included, and the definitions used vary across the various studies, the trend line, as shown in Figure 1, is clear.



---

[11] Ross M. Mullner and David McNeil, "Rural and Urban Hospital Closures: A Comparison," Health Affairs 5(3):131-141, Fall 1986.

[12] These states are Alaska, Idaho, Kansas, Mississippi, Montana, Nebraska, North Dakota, South Dakota, Utah and Wyoming.

Given this, it is difficult, to understand the rationale behind the "deal" agreed to by the Congress and the Administration as part of the budget summit last year. Simply put, the increase in standardized payment amounts would vary from 1.5 percent to 2.5 percent less than the costs of goods and services purchased by hospitals (the "market basket"). In addition, capital expenditures would be reimbursed at 88 cents on the dollar until October 1, 1988 when payments will be reduced even further, to 85 cents on the dollar. Furthermore, although it is well known that PPS cannot adequately measure severity of illness within DRGs and that the indirect teaching adjustment was an explicit proxy payment for that problem, the Administration's budget includes a proposal to cut the indirect teaching adjustment to 4.05, which is below 1983 levels. They have also proposed further reducing the direct teaching payments. It spite of these revenue curtailment measures, Americans expect, if not demand, that our nation's hospitals continue to provide the newest technology and the best patient care. If present trends continue, I'm not sure that hospitals will be able to meet our expectations.

Any student of elementary economics knows that to improve margins one has to either increase revenues or decrease costs. It is obvious that revenues are being curtailed, but can hospitals further decrease costs? More importantly, can they decrease costs without sacrificing quality?

Hospital costs have risen rapidly since 1980 in response to better technology and new techniques available now to diagnose and treat disease. At the same time, hospitals have had a strong incentive to reduce costs since the advent of prospective payment. Matching increases in costs to increases in revenues, a hospital with an average Medicare margin in 1985 would have to have an increase in expenses of less than one-half the national average just to have a positive Medicare margin in 1988. Unfortunately, even with the strong incentives to control costs present in the system, only about one-half of all our nation's hospitals were able to achieve this.

In order to reduce costs, hospitals must look first to labor expenses, which represent around 75 percent of a hospital's expenses. Nurses are an important component of a hospital's labor expenses and all evidence suggests that hospitals will need more nurses and to get them they will have to pay higher salaries. As a result of medical advances, hospitals required nearly twice the number of nurses per 100 patients in 1986 as they did in 1972 (50 per 100 patients in 1972 and 91 in 1986). This suggests that there will be a need for even more nurses in the future. Higher salaries are required to convince people to become nurses and to retain the current supply of nurses. Again, elementary economics suggests that in order to increase the supply of nurses, higher salaries will be necessary.[13]

Hospitals may also be able to reduce labor costs by trimming their administrative staffs, and perhaps some savings are possible there. As a physician, I feel about administrators about the same way Shakespeare felt about lawyers, but I am not sure that substantive reductions are possible given the regulatory and other administrative burdens placed on a modern hospital. In short, it does not appear as though hospitals will be able to achieve any substantial savings in labor expenses, one of the only major factors over which they have control.

In summary, if present trends continue the health care delivery system we have come to expect for ourselves as well as for Medicare beneficiaries and indeed all Americans will be in serious jeopardy. Access to care will be severely restricted particularly for the Americans living in rural areas. Hospitals that serve the most vulnerable among us would likewise be affected first. The training of our next generation of physicians would be severely impacted. It would be easy to conclude that all that is necessary to preserve our health care system is more money. That conclusion would, by itself, be wrong. We must, of course, root out fraud, waste and abuse from our health care delivery system. I doubt, however, that this will be sufficient. We must also commit ourselves to providing adequate funding for our health care providers rather than viewing public programs as a vehicle for solving budget deficits.

---

[13] Linda Aiken and Connie Mullinix,"The Nursing Shortage: Myth or Reality?" New England Journal of Medicine 317(10):641-646, September 1987

Chairman **Stark**. Thank you both.

Dr. Anderson, as I mentioned earlier, California hospitals' costs are among the highest in the Nation, and therefore, as we move toward national rates, these hospitals have the largest reduction from their 1981 base. We have heard testimony that that base may not be relevant because it was way too high.

Why can't California hospitals reduce their costs to more closely approximate the average DRG rates?

Dr. **Anderson**. I think you want to take a look at two factors—first of all, the market basket, or make the adjustment factors, and then take a look at the types of patients which are being treated.

In 1979 I was in the Department of Health and Human Services, and I was asked by people in New England why don't we take into account the higher energy costs associated with the oil embargo, and the New England hospitals were complaining that the market basket didn't take into account their concerns. So we developed regional market baskets, and we found that indeed, it might help them a little bit, but it wouldn't help them a great deal, either in terms of rates of increase or in terms of level adjustment.

If you look at what has happened in the last several years, they certainly wouldn't want those types of adjustments because energy costs have dropped down and they are not a very large percentage of total expenditures.

So I think what California would find if it made a whole series of adjustment for regional market baskets and nonlabor components is that maybe in the short run it might get a little bit more money, depending on how it worked out in that particular year; but over the long run, it would not. What we see is very little long run differences in terms of cost of living across the United States or in terms of the rates of increase across the United States.

So I think this is probably much more of a short-term phenomenon and not a long-term phenomenon.

In terms of case mix differences, however, I think there appear to be some significant differences between California hospitals and other hospitals. When I look at the California data, what I see is that 2 percent of the cases are responsible for almost one-quarter of all charges. Those are obviously the very high-cost cases.

Now, this percentage of case mix is different than most other States. So what I think you want to take a look at is the differences in case mix between California hospitals and other hospitals, and ways to make adjustments for that.

I would suggest that the solution, or at least a short-term solution to the problem, is by changing the outlier policy, something that Dr. Altman suggested earlier. I think what you want to do is make it easier to become an outlier, and when somebody becomes an outlier, to pay higher amounts than you currently pay for outlier adjustment.

I think the difference is primarily case mix, and I think the outlier adjustment would be at least a short-term solution to the problem.

Chairman **Stark**. You also suggest in your testimony that "hospital management has made few improvements in recent years."

You don't blame the managers, though; you say that there is no incentive to not spend money, so why not spend it? I think that is a fair summarization.

Mr. **Anderson**. Correct.

Chairman **Stark**. Is cutting rates enough external pressure to force hospital management to change? Actually, I think the DRGs have brought down hospital costs. I am sure that any institution, whether it is Congress, the Pentagon, the telephone company or General Motors, could probably have an across-the-board 10-percent cut, and there is so much marginal waste that the cut wouldn't hurt the institution at all. I suppose you could do that for a couple of years in a row, but at some point you really begin to affect basic operating systems, or critical personnel.

If you have a data processing function and three people working in it, you cannot cut down to zero. Maybe you can fire two of the three and save money, but obviously, if there is nobody there to run the system, it fails.

Could you comment further on what we might do legislatively, besides lowering rates, to force change in hospital managers and make them recognize that they cannot just come here and keep lobbying us for more money if they are not willing to make some changes themselves?

Mr. **Anderson**. First of all, you are starting from a period in 1983 when you passed prospective payment, when we thought that hospitals were bloated and were too expensive, and I don't know that we have seen substantial changes from that since then in terms of their operating behavior. So I to some extent disagree with the fact that we really lowered the rate of increase substantially in terms of real growth. What is lowered is inflation, overall inflation in the economy, not real growth in the hospital sector, and I think Dr. Altman's charts demonstrate that quite clearly, that there has been very little real growth in the hospital sector, or decline in real growth.

What kinds of things can we do?

I think what we want to look at is where hospitals are spending that additional money. I think if you look at the number of nurses per bed, they are increasing; if you look at the number of hospital staff per bed, they are increasing. And this is not surprising in an industry dominated by not-for-profit hospitals. They cannot do anything with their excess revenues except for putting it into additional capital or additional personnel, and in fact that is exactly what they are doing, and that is what economists would suggest that they were doing.

So one of the things you can do is to continue to hold down rates, and I am not convinced that they have been held down long enough or hard enough so that the hospitals indeed have been forced to change their behavior. In fact, the occupancy rates are going down, yet the beds are not closing, and the staffing patterns are still going up in terms of more personnel per bed.

What kinds of things you want to do are to include capital into the prospective payment system so that they have an incentive to look at the capital and to control capital spending as much as they are trying to control operating spending. That is certainly a legislative action you could take.

I don't know if "health planning" is the word for the 1990s, but certainly, it is possibly the word for the 1990s, and there are many hospitals which you have got to take a look at; you also should examine what kinds of services they are providing and what kinds of beds they have expanded, or what kinds of services are being contracted.

I think that is what you need to do.

Chairman STARK. Dr. Rubin, in your testimony you stated that on the average hospitals are losing 10 percent on their Medicare business. My staff reports that this statement contradicts every study that they have seen. I have heard that it is the other way around. In California, where the Governor has just cut Medicaid drastically, they are losing a lot of money on Medicaid, but are doing quite well, if you look at their figures, on Medicare.

Can you enlighten us as to what data you used and provide some more details for the record? I would be curious as to your response.

Dr. RUBIN. Sure. We would be happy to provide the technical details for the record.

[The information follows:]

HEALTH AND SCIENCES RESEARCH INCORPORATED MEDICARE HOSPITAL MARGIN METHODOLOGY

Health and Sciences Research Incorporated (HSRI) has done two separate analyses estimating 1988 Medicare operating margins. The first analysis was for 4,500 hospitals, and was completed in December 1987.[1] The second analysis was done in February 1988, and estimated margins for hospitals in California. Estimates of 1988 margins made in December were based on the PPS payment methodology specified in the September 1, 1987 Federal Register. Estimates calculated in February reflected recent legislation effective April 1, 1988. The following sections describe in detail the methods used in making these estimates.

A. Hospital Medicare Revenues

Medicare revenues for each hospital were estimated using the following formula:

Discharges * Standardized Rate * 1 + (Indirect Teaching Adjustment + Disproportionate Share Factor) * Hospital Case Mix

where:

Discharges - Medicare discharges from the PPS2 file.

Standardized Rate - (labor portion * wage index) + non-labor portion Wage index published in the September 1, 1987 Federal Register.

Indirect Teaching Factor - Calculated for teaching hospitals as follows:

$$((1 + (\text{intern}/\text{bed}))^{.405}) - 1) * 2$$

Disproportionate Share Factor - Factor from HCFA data set dated May 19, 1987.

Hospital Case Mix - Hospital case mix from the Federal Register.

Standardized rates for the national analysis assumed a 1.5 percent increase over 9/1/87 published rates and a fully phased in national rate. The rates were estimated using the national rates from the September 1, 1988 Federal Register deflated by 2.7 percent. The rates were then inflated assuming a 1.5 percent increase. This estimation process was necessary so that new wage indices and case mix numbers would be consistent with the rates used.

---

[1] Margins were not calculated for hospitals with data problems. Categorically excluded were hospitals in New York, New Jersey, Massachusetts, Maryland, and Puerto Rico.

Standardized rates for the California analysis were calculated assuming that rates effective April 1, 1988 were in effect for the entire year. Rates were estimated by deflating 9/1/87 published rates by 2.7 percent, and then inflating the rates by:

- 1.5% for urban areas with population over 1 million;
- 3.0% for rural areas; and
- 1.0% for other PPS hospitals.

In both analyses, payments were calculated based solely on national rates. In the California analysis, revenues were not calculated based on 85 percent of the national DRG rate plus 15 percent of the applicable regional rate because the blend did not yield higher payments for hospitals in the Pacific region. Payments to sole community providers were based on 75 percent hospital specific portion and 25 percent regional rate as specified in the regulations. Payments to regional referral centers were based on 100 percent of the urban standardized rates and the applicable rural wage index as stipulated in the September 1, 1987 Federal Register. Hospitals' sole community provider and regional referral center designations were provided by HCFA in August, 1987.

B. Hospital Medicare Expenses

HSRI estimated 1988 Medicare operating expenses for each hospital by inflating 1985 operating expenses reported on the PPS2 files. In order to account for differences in fiscal year end, each hospital's expenses were first deflated to September 30, 1985.[2] Operating expenses were then inflated to September 30, 1988 under two assumptions:

1) expense increases equal the hospital market basket; and

2) expense increases equal to two times the market basket.

Table 1 shows the assumed percentage increase in costs from 1985 to 1988.

TABLE 1

Hospital Operating Expense Increases

	1985-86	1986-87	1987-88
Market Basket	3.2%	3.5%	4.5%
Two-times Market Basket	6.4	7.0	9.0

---

[2] The deflators were adjusted for the assumptions regarding increases in expenses.

C. Results

1. National

Table 2 summarizes the findings on 1988 hospital Medicare operating margins from our first analysis, which was conducted prior to legislation specifying a separate standardized rate for hospitals in urban areas with a population of over one million. This table also shows hospital Medicare operating margins calculated for 1984 and 1985.[3] Estimates shown in Table 2 are based upon data from 4,500 hospitals.

TABLE 2

Hospital Medicare Operating Margins for 1984, 1985 and Forecasted for 1988

	Margin
1984	14.4%
1985	14.0
1988	
1 x Market Basket	2.9
2 x Market Basket	-5.2

The margins in Table 2 for 1984 and 1985 are close to those reported by ProPAC.[4] Estimated margins for 1988, assuming expenses increase at one times the market basket, show a 79 percent decline over 1985 margins. Estimated margins that assume expenses increase at two time the market basket are negative in 1988.

---

[3] The margin used in all tables is defined as (revenues - expenditures) divided by revenues.

[4] ProPAC reported hospital margins based on PPS1 and PPS2 data for 2,233 hospitals. The FY84 PPS operating margin was 14 percent and the FY85 margin was 14.3 percent. ProPAC's estimates were based on data for about half as many hospitals as HSRI estimates.

2. California

Table 3 summarizes our findings on hospital margins for California hospitals using the regulations in effect after March 31, 1988.

TABLE 3

1988 Hospital Medicare Operating Margins
Forecasted for California Hospitals

	Margin	Number of Hospitals	Number of Hospitals with Negative Margin
1 x Market Basket	1.6%	449	202
Teaching	2.9	94	33
Non-Teaching	0.8	355	169
2 x Market Basket	-7.8%	449	276
Teaching	-6.3	94	54
Non-Teaching	-8.6	355	222

Table 3 shows California hospitals' estimated margins are lower than the national average margin.

3. Importance of Assumptions

The results presented in the tables indicate that margin estimates are sensitive to assumptions regarding the rate of increase in hospital expenses. The question then becomes what is a reasonable and realistic estimate of the increase in hospital expenses.

Assuming hospital expenses have increased at the market basket over the period from 1985 to 1988, the total increase in expenses over the period is 11.5 percent. As shown in Table 2 this assumption results in average hospital margins of 2.9 percent. At twice the market basket, expenses over the same period increase by 23.9 percent, resulting in a margin of -5.2 percent. These estimates imply that if hospital expenses have increased by any more than 16 percent over the three year period, the average hospital margin will be negative.

ProPAC analyses of PPS2 and PPS3 data indicate hospital Medicare operating costs increased 6.5 percent between 1986 and 1987. A 6.5 percent increase in costs is more than double the market basket. Factoring in a 3.6 percent decline in cases shows the cost per case between 1986 and 1987 actually increased 10.4 percent, an increase of more than triple the market basket. This indicates that margins estimated assuming that expenses have increased at twice the market basket are likely to be the most reasonable.

Dr. **Rubin**. The margin analyses were done using the presumed payment rates for this current fiscal year. They were done—and we can go into all the details in terms of all of the assumptions—but it basically assumed that expenses increased at twice the market basket.

In doing an analysis for California hospitals, for example, we would estimate that on average, Medicare margins would be negative in fiscal 1988. That result, I don't believe is dissimilar from the California Hospital Association.

Chairman **Stark**. Yes, but the California Hospital Association based their study on a couple hundred hospitals, and were very selective in the ones they picked.

Dr. **Rubin**. Yes. We looked at all of the hospitals, 449 hospitals, and came up with an average negative Medicare margin of exactly 7.8 percent.

Chairman **Stark**. And you allocated costs equally on every admission, or how did you——

Dr. **Rubin**. No. We looked at average costs—revenues per discharge based on what one would expect given the payment rates, and then we added in disproportionate share, teaching adjustment, et cetera.

Chairman **Stark**. Go back a minute to when you said "on what one would expect"—what was that? I missed that statement.

Dr. **Rubin**. Based on the standardized amount and the update—as has been pointed out, there will be a number of updates during the current fiscal year. We factored all of those in and assumed a standard. The one thing we did was assume a standardized fiscal year for all the hospitals, because of the transition and not knowing when a hospital's fiscal year began and ended; we standardized that. We would be happy to provide that information.

Chairman **Stark**. I guess I am missing something. You took actual costs for each hospital?

Dr. **Rubin**. No. We took projected costs.

Chairman **Stark**. Why didn't you use actual data? I mean, it is available.

Dr. **Rubin**. Because it is impossible.

Chairman **Stark**. California requires it.

Dr. **Rubin**. Not 1988.

Chairman **Stark**. Well, for 1987—1986, certainly.

Dr. **Rubin**. Well, we took baseline data and inflated it by the market basket to get a 1988 number.

Chairman **Stark**. I guess what I'm saying is that in California we have actual cost and income records for each hospital, and if you look at those, it is pretty hard to find hospitals that are losing money on Medicare. Now, I suppose you could fuss around with lots of averages, and you could drown in a stream 2 inches deep on the average, but what I am wondering is why didn't you use actual figures?

Dr. **Rubin**. Number one, we didn't have the actual figures, as I said, and this is what we believed would be most appropriate for the particular——

Chairman **Stark**. I guess that is my problem, particularly in California, when you look at the actual hospitals, they are doing all right. They are breaking even at worst, and making money at best.

Dr. RUBIN. On Medicare?

Chairman STARK. Well, it is pretty difficult to segregate Medicare from Medicaid from Blue Cross from anything else.

Dr. RUBIN. Well, it shouldn't be very difficult at all, Mr. Chairman. You take a Medicare patient; you know what the DRG is going to be. You should be able to figure out the precise payment amount for that patient, and then you should be able to develop some methodology to know what it cost that hospital to take care of that patient, particularly if there is specific hospital data for California hospitals.

Chairman STARK. Well, let me put it this way, Doctor. Any hospital, if they choose, could refuse to take Medicare patients. I would assume that you would give management the credit for that decision. These hospitals do this year after year; they don't go to jail if they don't take them.

If Medicare patients were such a money loser, why wouldn't they just refuse to take them?

Dr. RUBIN. Well, I can't speak for all hospitals in California. My sense is that if hospitals on the whole were breaking even that there is a sense of community responsibility for taking care of Medicare patients in much the same way that people in the past have taken care of Medicaid patients, and certainly not broken even in large numbers of States across the country.

But individual hospital administrators I am sure have individual motivations.

Chairman STARK. Well, as I have said, I would like to see your California data. I am particularly intrigued as to how you got actual receipts and actual costs, because from the figures that I have seen, those hospitals which complain the most loudly when you see their individual data, are funning us. They are using a lot of averages to tell you that they are going broke, when they aren't. It becomes very difficult to trust the numbers when they are so artfully gamed.

We have seen no other study that suggests that on the average hospitals are losing on their Medicare business, and that is why I will look forward to yours with some——

Dr. RUBIN. Are you talking about hospitals across the country?

Chairman STARK. Yes.

Dr. RUBIN. Well, the data I cited not only was part of a study that we did for the Department of Health and Human Services, but comports almost identically with the ProPAC study. And if you look at page 6 of my prepared statement, you will see a chart entitled, "Hospital Margins 1985 to 1988".

Chairman STARK. I am told that ProPAC said that at best their 1988 margins suggested zero.

Dr. RUBIN. That is exactly right. And if you take a look, as I indicated, at the figure we provided in the prepared statement, you will notice there are four studies that are cited: ProPAC's; our own; the American Hospital Association, which looked at total margins, and then the Hospital Financial Management Association, which also looked at total margins. And what you will see, I believe, is that the ICF study and the ProPAC study have almost identical slopes. If anything, ours are slightly higher.

But we will be happy to provide the precise methodology.

Chairman **Stark**. Do you have any comments on that if hospitals are losing money, that perhaps they ought to go out of business? Is there anything wrong with that?

Dr. **Rubin**. No. As a matter of fact, when we put forward the PPS system, we had no doubt that hospitals would go out of business, and I personally believe that that is completely appropriate.

I think that we ought to be very careful about which hospitals go out of business, since I don't think we want to restrict access to care, particularly in both rural areas as well as certain inner-city urban areas, particularly with public hospitals.

Chairman **Stark**. Well, on page 6 of your testimony you mention Cottle County Hospital in Paducah.

Dr. **Rubin**. Right.

Chairman **Stark**. Where do those people go now, those 2,200 people?

Dr. **Rubin**. Some of them go to Abilene, which is about 125 miles down the road. I am not enough of an expert on Texas geography——

Chairman **Stark**. Well, I just happen to have the atlas here. What is wrong with Childress, which is 32 miles up the road? They tell me in Paducah that is where they go. It is a perfectly good hospital, and it looks like a straight and narrow road. You have to slow down for Dunlap, but other than that, by almost any standards 32 miles isn't too far to drive. By Texas standards, that's 20 minutes. [Laughter.]

Is there anything wrong with that?

Dr. **Rubin**. Well, there may not be anything wrong with that.

Chairman **Stark**. It takes longer to get from here to those fancy hospitals up in Northwest Washington during rush hour—and it is probably more dangerous. So what's wrong with closing a hospital in a town of a couple thousand people and directing those resources toward other hospitals in the area?

Dr. **Rubin**. I think that what we have found, at least in my experience, is that sitting here in Washington, there is nothing wrong with it. In fact, it may even be good. It is not clear that the people of Paducah who, at least according to the press article that that item was taken from, are now having trouble recruiting physicians, think that it is that good, and that really is the crux of the problem.

I remember when I was teaching in Boston, the State tried to close down a small hospital in Ipswich, which is slightly north of Boston, and finally, after—gee, I don't know—about 4 years, they succeeded only because it was bought by another institution and turned into an outpatient clinic.

I applaud closing hospitals. There is no question that we need to close hospitals and probably should close more of them. I just get concerned if we close the wrong ones.

Chairman **Stark**. Well, it seems that the administration would have us close hospitals based on competition. It would seem to me that you would advise anybody who needed major surgery in Ipswich to get themselves off to Mass General and go——

Dr. **Rubin**. Actually, I would have said the New England Medical Center, where I practiced.

Chairman **Stark**. All right, or there. But I mean rural hospitals just may not be as efficient. Transportation is now getting more efficient. So I think that is a fair tradeoff.

The system has said to let the basis be the DRGs. When we do that, the people claim you are losing money on Medicare. Well, I guess that is what some hospitals will have to do and then they'll close.

I know that is terribly harsh. I certainly don't want any hospitals closed in my district, and Mr. Gradison doesn't want any closed in his district. But the fact is, if the system is going to work—and I am not suggesting for a minute that we cannot throw the whole system out. My alternative would be a national health system, and I don't think many people want that either. So what I am saying is, is it all that bad if somebody doesn't make money on DRGs or if a hospital closes; isn't that the price we have to pay?

Dr. **Rubin**. Absolutely, yes. I agree with that. I don't think it is too bad, and I don't think it is something that we particularly want to protect against except, it seems to me, under two circumstances. First, the people from the GAO may not have carefully looked at the nonrandom distribution of hospitals that treat people on the high end of within DRG variation. And in point of fact, if hospitals through no fault of their own are caught at the high end of the severity spectrum, and for example, Stu Altman mentioned burn center hospitals—I guess in terms of full disclosure, I should tell you that we have done work for burn center hospitals, and they have a real problem. Burn centers see a disproportionate share of severely burned patients, and they are on the short end of the stick when it comes to payments.

I think the system ought to try to protect those hospitals with a nonrandom group of severely ill patients, and in point of fact, since 1983, people have been looking for a way to deal with severity of illness, and we still have not come up with, or at least the Department has not proposed, a good way of doing that.

The second instance would be hospitals that take care of people that don't have the kinds of alternatives that we just talked about; and that would be people in the inner cities where there really are not a whole lot of—there may be hospitals not far from them, but they really don't have that kind of an opportunity. I think the public hospitals, because they are the hospitals of last resort—and I believe they are in California—must take patients by law that other hospitals, for whatever reason, may not have room for.

So I think with those two exceptions, I don't have any problems with any particular hospital closing.

Chairman **Stark**. Great. Thank you.

Mr. Gradison?

Mr. **Gradison**. Thank you, Mr. Chairman.

Dr. Anderson, if I understand what you have said so far, it is that a further tightening of hospital management and personnel expenditures would not adversely affect the quality of care.

And Dr. Rubin, if I have understood you correctly, it is that a further tightening of hospital expenditures and personnel would adversely affect the quality of care.

I am not trying to put words in your mouths. I just want to make sure I understand what you are saying, because if my understanding is correct or approximately correct, I would appreciate a brief explanation as to why you disagree with each other.

Mr. ANDERSON. I think in the statement that "would not" is different from "has not." And I think in the past what we have seen is that all the reductions that you have made have not changed the quality of care, and that there is a great deal of excess revenues left in the system which can be taken out of the system.

Since 1983, both personnel per bed and capital per bed they have increased, they have not decreased. So if you just got back to 1983 levels, which you passed prospective payment because you thought there was a little too much excess in the system at the time, getting back to 1983 is at least a goal that I would do, let alone trying to do what you were trying to do in 1983, which was to roll expenditures back because you believed the cost-based reimbursement let hospitals be too fat.

So I think what I am looking at really is what has happened from 1983 to 1987. If you continue to control Medicare rates way below market basket for a long period of time, sure, there will be quality declines, significant quality declines, significant access declines. But I think if you look in the short term being 2, 3 years from now, I don't see those drastic reductions in quality of care. I have been looking for them in a variety of ways and have not seen them.

Mr. GRADISON. Dr. Rubin, do you want to join in this debate?

Dr. RUBIN. I would be happy to. I appreciate the question.

There is an old saying in medicine to beware of the man with one case, and I would caution you to take what I am about to say in that regard.

I don't know about the institution where Dr. Anderson teaches, but at the institution where I practice, the patients are sicker; they do require more nurses to take care of them. I just finished 6 weeks on the wards at one of those teaching hospitals in the northwestern part of the city that I think is reasonably efficient, and we have patients on the general wards today that we would have put in the intensive care units 3 or 4 years ago—patients with AIDS who are on assisted breathing, who are on fairly toxic chemicals, who require monitoring.

It is no accident that the number of nurses have gone from 51 per 100 patients in 1972 to 91 per 100 patients in 1986. The nature of hospital care has changed.

I'd like to think that part of that change was due to the prospective payment system. Dr. Anderson in his testimony talks about how you hardly ever see any patients in the hospital who have cataract surgery. Well, the medical equivalent to that is that when I was an intern in 1970, we regularly used to be given a rotation on a particular ward of the New England Medical Center that was kind of a month off, because we used to regularly fill the ward up with executives from a large automobile company who used to come in for their 3-day x rays—and sometimes I thought that the doses were probably therapeutic rather than diagnostic. But they used to get every orifice poked at, and they used everything you could pour contrast media had it poured into. It was an intern's delight.

Interns at New England Medical Center don't have that month off anymore. Every single patient that they see—and over 40 percent now come in through the emergency room, and the rest are referred from some of the hospitals that Mr. Stark mentioned.

So, my experience is—and I guess it is more than just one example—that the patients are a heck of a lot sicker and really need the kind of care that they get. And maybe Stu Altman was right; maybe they don't all need to be registered nurses, but they certainly need to be a lot more skillful and have specialized knowledge than they did, certainly, in 1970, and at least in my experience, certainly since 1981 or 1983.

Has the quality of care declined? I don't think so. I don't know. I sure wish somebody would figure out a good way to measure quality so that we could know for sure, rather than speculate. But I think that quality is too important a trait for our health care system to be in doubt about, and I do believe that we are on a fine line, and if we haven't tipped it over yet, I think if we continue in the same vein, restricting or curtailing payments relative to costs, that we sure will get there fairly quickly.

Mr. ANDERSON. May I?

Mr. GRADISON. Go ahead.

Mr. ANDERSON. One of the arguments—and Dr. Rubin made it—is that the case mix is indeed changing. And the data—and I don't subscribe to that the DRGs are the best measure of case mix, and there are lots of improvements to be made—but if you look at the Medicare case mix, it has not since 1983 gone up substantially. For example, in 1985, the overall case mix average was 1.18; in 1987, it is 1.22—a 4 percent increase.

And if you look at Rand's study and other studies, they suggest that much of that is due to up-coding; the fact that it is the same cases, but they have learned how to work the system a little bit better. So at least, as measured by the DRGs, the case mix changes from at least 1985 to 1987 have not been all that substantial.

Mr. GRADISON. May I ask one other question, please, Mr. Chairman?

Chairman STARK. By all means.

Mr. GRADISON. Thank you.

A recent study indicates that there is about a 1 percent premature discharge rate, but about a 10 percent unnecessary hospitalization rate in the same institution. I just wonder whether those figures make sense to both of you in terms of your understanding of what is happening out there. Do you have any serious order of magnitude questions about the accuracy of that kind of a report—because it does suggest that there is a possibility for substantial reduction in hospital expenditures by moving those cases somewhere else where they still might need care—the unnecessary hospitalization cases where they no doubt require some kind of care, but perhaps less expensive care than would be available in an acute care hospital.

I wonder what your thinking is on that.

Dr. RUBIN. I have no doubt that there are unnecessary hospitalizations. And clearly, those ought to get down as low as possible. Frequently, however, those people go to the hospital because there are no other facilities available. There is clearly a shortage of nursing home beds; there is clearly a shortage of home health services in various parts of the country. So I think those are things we need to work toward.

Sometimes, at least with the Delmarva PRO, an "unnecessary hospitalization", is probably true on medical grounds, but on social and humanitarian grounds, it is very clear that the patient needs to be in some sort of a protected environment, and we have seen a few of those at our institution, where it would be just inhumane not to admit the patient to the hospital and take the financial risk.

Mr. **Anderson**. I think the hospital industry is doing a very good job in moving people out of the hospital. Where cataract surgery was the third most common DRG in 1984, it wasn't in the top 50 by 1986. So they have moved a great deal in moving a lot of these unnecessary admissions out of the hospital.

And that 10 percent number, I know the physicians at Johns Hopkins Hospital are mad at Delmarva as well about a lot of these unnecessary admissions, and there is an ongoing revolt against what is considered to be an unnecessary admission.

In terms of premature discharges, we are taking a look at that in a study from the Johns Hopkins Hospital on what are premature discharges. What we are finding is that there is a very real problem in terms of the after-care to which is just not available, causing a lot more what we think are unnecessary deaths or readmissions, which increase the overall health care costs. We believe a fairly small amount of money put into after-care will actually have a significant reduction in overall health care costs.

Mr. **Gradison**. Thank you both very much.

Thank you, Mr. Chairman.

Chairman **Stark**. I would like to join in thanks. I do look forward to receiving whatever additional data we might get, Dr. Rubin, on the study that you made. I am sure that the staff and I will find it interesting.

Thank you both for your testimony.

Saving the best for the last, as we often do, our next witness is Jack Owen, executive vice president of the American Hospital Association.

Jack, it will be our intention to work right on through to the completion of your testimony and inquiry, so you may proceed in any manner you care, and to summarize or expand on your prepared testimony.

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. **Owen**. Thank you, Mr. Chairman.

You have my testimony, and one of the advantages of being last is having the opportunity to make comments on those who testify first; but of course, it is a disadvantage from the standpoint of having to sit here and listen to a lot of people who have never really had to deliver care comment on how best to do it. That is difficult.

I do have one comment to start out with. You asked what you could do to solve the problem of legislation. I say that if Congress could pass a law which would legislate good health to everyone, we would solve the whole problem completely, and we wouldn't have to worry about what is going on.

Chairman **Stark**. The trouble is that we would have to wait so long for HCFA to tell us whether it worked or not.

Mr. **Owen**. That is correct.

Let me say first off that I would like to commend you personally, Mr. Stark, for your position on abiding by the budget summit agreement that was agreed upon in December. We certainly do not need additional budget cuts this year and we will support you whole-heartedly in that. We also want to commend you on this hearing, which is not designed to renegotiate those issues, but to look at what some of the problems are and hopefully, look and see if some fixes might occur.

Chairman **Stark**. Yes. I would like to reemphasize that, Jack. I think it is Chairman Rostenkowski's position as well, and assuming that we can hold that position in the Budget Committee, there doesn't seem to be any real need at this point to rehoe the ground we worked on last year.

I know there are some elements within your own Association that think they might be able to improve their lot in life, financially speaking, through some fine-tuning of the budget agreement. But I say this not as a threat, but just that my experience is that once we open Pandora's Box, various hospital groups who might think they want, through some minor adjustment, to improve their lot in life, may end up with very much less.

And without any certainty, I think that what we did last year in the aggregate would best serve the entire hospital population. But a lot rests on the decisions of the Budget Committee. We appreciate your support in that regard.

Mr. **Owen**. I do think, however, that we have a problem of equity. And whether it can be touched this year or not, I think we ought to start preparing for it. I was glad to hear Congressman Gradison mention our Medicare reform plan, because I would like to just talk a little bit about that before I get away from here.

Basically, I found it hard to believe as I sat here and listened to CBO explain the problems with the charts, because if you will recall, three years ago, I testified at this hearing and in your offices——

Chairman **Stark**. That was GAO, by the way, the Auditor General——

Mr. **Owen**. I am sorry; GAO.

Chairman **Stark** [continuing]. Not the also equally maligned Congressional Budget Office.

Mr. **Owen**. Okay. I testified that if we were going to avoid the problems we were facing, we would have to look at an adjusted or a blended national rate, and a coefficient of variation. And that is exactly what GAO was using—coefficient of variation.

One of the difficulties they were pointing out was basically that you cannot market for just one kind of DRG, because variations occur within the DRG, and if you went out to say, well, I'm going to just try and market for this kind of DRG, you don't know what kind of patients are going to come in with that particular diagnosis. So you don't stand a chance, really, of saying we are going to win if we stick with just this particular DRG, and we have discovered that right along.

I think the other thing that we tried to point out earlier in this game is that there is a correlation that develops over a period of time, and that is that as you look at that coefficient of variation, you find that there are about 15 percent of cases on the upper level that will not have very much of a variation, and that most of those DRGs will be similar, not matter what kind of institution they go in.

On the other end of that scale, there are about 15 percent that will never be alike, that there will be a great variation in. And somewhere in between, in about 70 percent of cases there is some degree of variation that occurs.

So I was pleased, I guess, as much as anything to hear that there still is some hope that we are going to look at a blended rate and try to get off the averages, which are confusing to everyone, because averages, as you pointed out, do not really demonstrate where we have problems. The industry as a whole looks good—well, the country as a whole is crime-free. But on the other hand, I wouldn't want to walk down the street late at night in some of our major cities with some cash in my hand. The same thing is true with many of us who want to go to a hospital. If the industry as a whole is doing fine, we still don't want to go to one of those hospitals that was described as being run-down, worn-out, and lacking the necessary care that any of us might need at a particular time.

So I think we have got to correct that.

One of the other comments that you made was about the number of empty beds, and that has been a concern to a lot of people, more of a perception, I think, than real.

It is interesting to note that there are fewer hospital beds today than there were in 1979 in this country. We are in a situation where there are fewer beds.

Chairman **Stark**. Jack, let me interrupt, if I may. I am going to dash and make this vote. Mr. Gradison and you may talk awhile on the record, and I will try and get back in time for him to vote, and then we'll continue. I will be right back.

Mr. **Owen**. Okay.

So I think what we are seeing is that there is movement.

The other thing that was pointed out is that in the DRG system, unlike the cost system, even though there are some empty beds, the payment for those beds is not being paid in the same fashion, so that a hospital is losing, and the Government is not necessarily paying because so much is tied up in that DRG price, and with the reduction in the capital, you have already discounted that considerably.

You asked, Mr. Gradison, about the number of hospitals that are in the red. Our figures show that in 1986, 50 percent of all community hospitals experienced a net loss on patient margin.

Now, that same figure showed that 25 percent had negative total margins within the hospital. That includes those things that are nonpatient revenues that might come in that would bring the margins up.

Mr. **Gradison**. What are the main factors there? Are they return on investments and things like that?

Mr. **Owen**. Correct. Return on investments may be funds that are raised in the community through fund drives; maybe from gift shops; it may be parking lot fees, television fees; things that might not be paid for out of reimbursement system or out of DRGs or Blue Cross.

Mr. **Gradison**. Would that differential also include some of the newer activities that institutions are getting into through subsidiaries that are not directly related to care in the hospital itself?

Mr. **Owen**. Yes, if that money flows back into the hospital—and usually, that's the reason they are in that particular activity—so, yes, that would include that.

The other point that I'd like to make is that there was a comment made by several of the witnesses about extra money that was thrown into the program at the beginning of this prospective payment system. I would argue that there was no extra money thrown into the system.

The point that we must go back and remember is that what Government was attempting to do was provide predictability in payout from the trust fund. The trust fund was going to go bankrupt by 1987. And I remember testifying on a panel following Nancy Gordon from, I believe, CBO in this case, mentioning that the total dollars that were going to flow out of the Medicare fund was going to jump somewhere around 15 or 16 percent per year, which it had been doing—unless something was done. And what the Federal Government wanted to do was to stop that massive flow of funds and to make it predictable and know in advance.

So a deal was struck saying in effect that whatever costs were in 1981 and 1982, that would be where we would start, and we would not go above that. And the hospitals lived up to that, and the predictability was there for the Government. No more money was spent. It wasn't extra money that was thrown in. But what happened was that because there was a profit—there were a lot of one-time savings—the hospitals were accused of being paid surpluses funds which, unfortunately, made them look like they were doing something that was not proper or that surpluses or profits were bad, when the Federal Government was not really concerned about it. They were interested in the payout. And we switched our thinking around so that we are now not interested in the payout as much as whether hospitals are making money or not. And that to me is more of a threat to the prospective pricing system than talking about what happens if you go back to a cost reimbursement system, because we are falling into a trap. We are falling into the trap of saying to a hospital, if you make money on a price that I have given you, I am going to have somebody show the country what you are doing; you have made a big profit. So why should I worry about making that profit—if my costs go up, and I am still well within the price, then I am not looked upon as doing something bad.

Mr. **Gradison**. Heads, I win; tails, you lose.

Mr. **Owen**. That is exactly right. And I think we have to get off that dime and look at what it is we want to do. We want to protect the trust fund; we want to have a fair price for hospitals and not criticize them every time they do something that is right.

Now let me just take a couple of seconds, if I could—and I am sorry that Mr. Stark is not here, because he would probably find it hard to believe that I would agree with him that the time probably has come to do some recalibration or rebasing.

We had quite an argument about this a year ago, and I believed we could accomplish all this in the price without going back to look at the cost. But I think we do have to, and because the costs have increased so much, it seems to me that we are going to have to recalibrate and come up with some kind of a standardized rate at this point in time.

The costs, whether they were real or whether they were not, are perceived as being out of line, and we will never convince Congress nor any of the bodies that represent Congress that we are doing something right unless we go back and do that rebasing or recalibration.

So I think that is necessary that we do that.

Now let me just take a couple minutes, if I could, and talk about what it is that we think could be done from the standpoint of the——

Mr. GRADISON. Jack, could I ask you one more question because then I have to go, as we only have so many minutes left on the vote.

Mr. OWEN. Yes.

Mr. GRADISON. It looks like we might not have reconciliation this year. Many of us are pleased about it. Are you pleased or not pleased? Are you willing to have another roll of the dice this year, or would you just prefer we didn't have reconciliation?

Mr. OWEN. I would prefer to leave it stand where we are, with what was accomplished in December of 1987.

Mr. GRADISON. Thank you. I regret having to go. My chairman has returned, and I gather you were going to surprise him with some comments on rebasing, and I want to encourage you to repeat those for his benefit.

Thank you very much. Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Go ahead, Jack.

Mr. OWEN. I said while you were out, Mr. Stark, that as much as I debated with you last year about rebasing and how there was no need for it, that current perceptions and what has happened with costs are undoubtedly a reason for recalibrating or rebasing and starting out anew from this point. The time has probably come to do that.

One thing I would like to comment on is that all of the statistics—and I know you are quite concerned about the cost reporting system—all of the statistics that were presented by GAO on those DRGs are available. They are reported now. And my point on the cost reporting system has basically been that we are not using what we have and that——

Chairman STARK. Let me interject there, Jack. We have costs. What we do not have is income. It is awfully hard to make judgments with only half of the equation. That is really the principal problem.

We could build these reports, rather than accounting with just a little more information, or different information.

Mr. Owen. My debate with you would be that if you have the costs for Medicare, and you are setting a price for Medicare, that is really all you need.

Chairman Stark. There is also the accountants' debate. I can gain, believe me, any accounting report I want if I am running a hospital. Allocation of costs has been going on in the industry since Chester was a pup, and it is not unique to the hospital industry, the auto industry, or anyplace else. There are whole universities full of Ph.D.'s that deal with cost accounting and cost allocation.

I think it is important to know, even if I have got to suffer the wrath of whoever represents Choctaw, Tex., to know whether or not it was Medicare reimbursement that did in the Choctaw Town Hospital; or if there were other factors.

I do not believe you cannot do this in a vacuum and make fair judgments, particularly when we are charged with other costs. We are charged with indirect medical education and disproportionate share burdens, which may or may not be a result of an aging population, but may be a result of economic changes. I understand the reluctance to show everything because people are used to dealing with a set of figures with which they are comfortable. But the facts are that people are saying, you, Congressman, are forcing us to go broke, and they say that loudly, it is, quite honestly, a lie. It then gives me cause to question other statements that these people make.

That is the kind of game we have gotten into. We are comparing apples and oranges; and in some cases Medicare may be woefully inadequate. In some cases, I am sure Medicaid is even more inadequate. In other cases, I have a hunch that we are fattening the pockets of many stockholders because certain hospitals are taking pieces of Medicare to make a lot of money on it.

Now, I think that when we legislate in the blind, it is a two-edged sword. Your members may win some, but as long as we are playing a zero sum game, for every winner there has got to be losers, in an era of budget constraint.

What I am saying is that it seems to me that we are all better off with more complete information. In this age of electronic marvels, that isn't much of a burden for anyone. That is my plea. If your association wants to lobby against it, I suppose for a while you will prevail. The only thing we can look for are ways to make that work economically to your advantage, and then I suspect your members will say, "What a great idea, Jack. We have always wanted to give all this information to Congress," and you will be here, explaining how you are going to do it.

Mr. Owen. Well, I think that remains to be seen. If I were going back and saying that Medicare was going to pick up some of the losses that might occur from some other area, there might be a lot more enthusiasm for doing that.

My problem has been basically in the fact that we don't fully utilize the data that we now have—and we certainly support the pilot study that you are going to do and seeing what is going to be done with it—and the other problem is that the decisions on DRGs and the prices have been so political and have had, really, no relationship to what was occurring in the industry. To go through the process of filling out all kinds of forms and then have nothing happen because a political decision is made to deal with the overall budget deficit, you have just created another kind of problem that is not helpful. I think you can understand that.

Chairman STARK. Actually, there is probably enough information supplied by now that I could stipulate that not one of your members would have to give anybody any information that isn't already being given to their trustees, their bank, or their State or Federal Government. All we have to do is get HCFA to collect that data and somehow kind of push it around a little bit to get some relevant information.

I really don't think that the hospitals would have to change much. I think that we would have to get a complete view of the hospitals rather than just their Medicare portion. It could vary from hospital to hospital—because if we are ever going to make it fair, as you want to do and as I want to do, you cannot make it fair unless you know what is fair. I think that for certain hospitals it is different from others hospitals.

Mr. OWEN. Well, we do think there is a way to make it fair with the data that is already available. Now, there may be some more that is needed. But what we would like to see in this year in looking at Medicare—and what might be done with it as we go into next year is to come up with a simple standardized rate. I am back to what we were talking about before. That standardized rate then is adjusted through either a coefficient of variation to represent severity, or a severity index with labor and non-labor.

What this does is avoid the urban/rural problem; avoid the disproportionate share problem; avoid the indirect medical education problem. All those things are possible and can be done, and that is not anything new. I have sat here in front of you before and stated the same thing.

So I hope that we can look forward to bringing more equity into the situation as well as adequacy, because even if we have equity, and there isn't enough money, and we don't stick with some kind of a market basket update and everybody loses, we haven't accomplished anything, and we are not going to be able to take care of the beneficiaries.

Chairman STARK. What I am getting at, Jack, is this: if we take California and New York, and let us just say, as we heard today, that the two are extremes, and that for the cost of a procedure or a DRG, let's say that California is $2,000, and New York is $1,000, and that the national average, just for the hell of it, is $1,500.

There is a $500 spread. New York is $500 under, and California is $500 over the national average. That is probably not too far from the actual figures in some areas. How much of that $500 deviation from the $1,500 national average would you guess is due to indexable costs like hourly rates, price per pound for beef, Btu's of energy, dollars per hour of nurses—not number of nurses, but dollars per hour? What would you guess you could find in indexes to account for that $500 deviation?

The remainder of the $500, then, you are going to tell me is just management practice.

Mr. OWEN. Right.

Chairman STARK. What's your guess?

Mr. **Owen**. I think you could probably index it, again, depending on——

Chairman **Stark**. By indexing, how much of the differential do you think we would take care of?

Mr. **Owen**. Well, it depends on what all you are going to index, but I think you could get as much as 90 percent.

Chairman **Stark**. You don't really believe that, do you?

Mr. **Owen**. It depends on what you are going to index. I mean, if you use a very gross kind of index and you say we are going to take one thing—labor——

Chairman **Stark**. No. Let's take it all. Let's take every item, but you can only index the unit cost; you cannot index usage.

Mr. **Owen**. Let me take the same example. Let's say we know that a DRG, whatever that case might be, we know what resources go into it, how many days of care and how much in the way of drugs and all the other things that go into it. We know that a standard average national rate, without taking in any of the variations——

Chairman **Stark**. Is $1,500, let's say.

Mr. **Owen** [continuing]. Is $1,500. Now what we are going to do is to say that that is what we pay across the country whether you are a rural hospital, teaching hospital, what-have-you. Then we index to that severity, the disproportionate kind of thing that you are talking about there, education, indirect education, labor, nonlabor, whatever else might go into those indexes. And you should come up with a fairly good—what you started with is you said we'll just make it $500, and we'll try to index up to it. I am not——

Chairman **Stark**. No, no. I just want you to tell me how much you think is——

Mr. **Owen**. In the $1,500?

Chairman **Stark** [continuing]. No—in the $500 spread. The $1,500, let's assume, is the average. We are willing to pay that amount.

Mr. **Owen**. But what I am saying is there is no spread in the $1,500.

Chairman **Stark**. But that same procedure costs $2,000 in California and $1,000 in New York. So there is a $500 spread to the lowest and the highest costs.

What I am suggesting is that out of that $500 spread, there is at least $300 that is just management decision; the decision to use one nurse per patient instead of three-quarters of a nurse per patient—not in the price per hour of nurses. In one area, the nurse gets $34,000, and in the other area, he or she gets $36,000. I don't think that can account for the difference in whether you use a half-a-nurse or a whole nurse per patient. And that is absolute management decision or tradition. I am suggesting to you that 60 percent of that variation are things we cannot index because they are done by habit, or by management choice.

Now, maybe you will disagree.

Mr. **Owen**. No. I agree with you that's what is happening now. I don't think we are at odds in what we are talking about here. You are taking what exists, and I am saying let's start over again.

Chairman **Stark**. OK. What I am saying is let us take those things that we can count—let's take beans in a pile—and do the best we can. And all I am further saying is that it is going to be impossible to make fair decisions unless we have all the numbers.

Mr. **Owen**. Yes. But there are differences in certain things we would agree on. There are differences in labor, there are differences in indirect——

Chairman **Stark**. Yes, I have repeatedly said that.

Mr. **Owen** [continuing]. All of those things that can be taken into account.

Chairman **Stark**. Right.

Mr. **Owen**. Let's see what those are——

Chairman **Stark**. Right, no quarrel.

Mr. **Owen**. All right—and then let's see what is left and set the price on the basis of that.

Chairman **Stark**. No quarrel, no quarrel.

Mr. **Owen**. I think Dr. Altman seems to think this is moving back toward a cost reimbursement system, and that is not what I am suggesting at all; that is not what our position is that it goes to a cost reimbursement system.

We are saying that you have to start somewhere with a standardized rate that is based on cost.

Chairman **Stark**. The trouble is that your members won't give us the numbers to put that together. They want to invent the indexes, and they cannot be trusted with that kind of economic power because they will follow their own economic self-interests. And again, you try to play that as a zero sum game, and you saw the results in the last Congress. You pair off States against other States. Then we get back to what has been referred to in the media as pork barrel; you are just scrapping over a limited number of dollars, and your association cannot take a position because it represents everybody.

All I am suggesting is that if we are going to get to a formula where there will be winners and losers, it would be nice to know the exact dollar amounts.

Mr. **Owen**. Well, it would be nice to get to a place where winners and losers were on the basis of management, not on the basis of something that good management cannot avoid, and I think that is what was coming out in the GAO is they get the wrong kinds of cases——

Chairman **Stark**. Do you think that can be done without closing hospitals?

Mr. **Owen**. Without closing hospitals?

Chairman **Stark**. Don't you really believe that we are going to have to see hospitals close in this country?

Mr. **Owen**. Well, there were 71 hospitals closed in 1986; there were 49 the year before and 41 the year before that.

Chairman **Stark**. That is still running less than one percent, right?

Mr. **Owen**. I think some hospitals will close.

Chairman **Stark**. Don't you think some should?

Mr. **Owen**. Probably, some should, that's right.

Chairman **Stark**. Even dues-paying members of the American Hospital Association—especially those in arrears?

Mr. **Owen**. No, not even those in arrears.

But I don't think that is—I mean, the DRG price is not going to stop a hospital from either continuing or closing. It is not the price; it is the number of admissions. If you gave every small hospital that was running a 30 percent occupancy the highest price that a university hospital gets with all the pass-throughs, they still would not have enough in order to keep it going.

So I think we have to separate the idea of price in a small hospital and lack of admissions away from what is a fair price for handling something; I think that is the important issue. And the second question is if we want a small rural hospital system, the DRG system is not the way to provide it, because it is not designed to maintain small institutions with very few admissions. It is based on big institution. That is why the bigger hospitals have done relatively better.

But the issue is that as long as you are paying averages, then there is always going to be somebody who is doing better. And if you say we don't want any profit, you are going to push everybody down below the bottom, and then we are going to have a very serious problem in this country of how to take care of the elderly. That is what worries me. And we have got to get off this average mentality and start paying hospitals for what they do, not where they are located.

Chairman STARK. I'm not sure I agree there. I am not willing——

Mr. OWEN. You don't think they should be paid for what they do?

Chairman STARK. Not if somebody else can do it for less.

Mr. OWEN. Well, the price that you set—you sit there as one who is going to set the price—not you personally, but using that as an analogy—you set the price, and you control that price, and I, as somebody who has to deliver the service, have no choice. I may argue I want a higher price, but I cannot quit, I cannot walk out. There is no way that I can say I am not going to handle Medicare, because——

Chairman STARK. Why not?

Mr. OWEN. There are too many other laws that preclude that.

Chairman STARK. Well, such as?

Mr. OWEN. Civil rights laws and all kinds of things; they are all tied to Medicare.

Chairman STARK. Well, if that is the only legislation—I would be glad to——

Mr. OWEN. You would be glad to pass an amendment that would allow us to freely decide?

Chairman STARK. You bet, you bet. I can suggest in my own district that we have many hospitals half full or half empty—you decide which it is——

Mr. OWEN. Yes, but I would respectfully submit that you may have a political problem.

Chairman STARK. Oh, I am sure it is a political problem.

Mr. OWEN. Not from hospitals, not from hospitals.

Chairman STARK. Well, the hospitals may be the first to holler. But I would suggest to you that if you cannot bid, we are going to continue to waste money. In other words, as somebody testified earlier, the managers have had no incentives to cut costs.

Mr. OWEN. Okay. But you see, that is where I get caught; that is where I get lost in the reasons for why you need all the information. If you are going to say, "Here is the price; take it or leave it," or if we are going to bid, what do you care?

Chairman STARK. We are not able to do that yet. That would be fine with me, but that——

Mr. OWEN. Then you wouldn't care about my costs, right?

Chairman STARK. Absolutely, you are right.

Mr. OWEN. Yes, okay.

Chairman STARK. But I think you would get more resistance from your members than if we were picking out the data.

Mr. OWEN. But that is what is happening to us, Congressman.

Chairman STARK. Well, it is not happening to you from Medicare, it is happening to you from corporations, and you are getting competition from HMOs, and you are getting insurance companies for the nonelderly Americans.

Mr. OWEN. But you are saying here is the price; it is not take it or leave it; it is take it. I do not even have the privilege of bidding. If I cannot do it—if I cannot say I cannot do it, I still cannot take it——

Chairman STARK. Yes. You do not have to take Medicare—or, you would go out of business, you would close.

Mr. OWEN. I have to take it right now.

Chairman STARK. No; you would close, basically.

Mr. OWEN. Well, I would close, right.

Chairman STARK. Or merge. Wall Street is going higgledy-piggledy. I do not know why the hospital folks have not caught on to that, it is very much the rage these days.

Mr. OWEN. It is hard—not too many people want losers unless they get a tax break, and that is no tax break, taking over a hospital.

Chairman STARK. I understand that, but as I say, it is very difficult for me to understand the mentality of hospital trustees or management who want to build increased capacity just for self-aggrandizement when the hospital is already underutilized. I do not think we should ask the Federal taxpayers to support that logic. And you are aware that it goes on.

Mr. OWEN. Well, yes, but as I was saying, I guess, when you were out of the room, there are fewer hospital beds in the country today than there were in 1979, and there are very few new hospitals being built at the present time. There are some, and I hasten to add that I know there are some, but overall the growth in the number of hospital beds is going down. It is not going up. There is some replacement, there are some other things that are taking place, but most of the construction is outpatient facilities, and that is increasing quite rapidly.

But on the other hand, Medicare is not paying, as I guess you learned from some of the other speakers, Medicare is not paying for those costs like they used to. In other words, you pay a flat price for a DRG, and if you only have one of them, that is all you get. And you have also reduced the capital by reducing the dollars coming in.

Chairman STARK. The net result of the system is that these hospitals are being built in California, which already has low occupancy and high cost; and New York, which has done a good job in the past of keeping cost down, is being penalized.

Now, is that fair?

Mr. OWEN. No. I don't know what fair is, except from the standpoint that New York has been a highly regulated system for many years.

Chairman STARK. And consequently, saves money.

Mr. OWEN. I guess that is one way——

Chairman STARK. It would be difficult to suggest that it has inferior quality, wouldn't it?

Mr. OWEN. I would not suggest that.

Chairman STARK. No, I wouldn't for a minute, either. And as a result of tough regulatory control—they may have over-regulated; I mean, there may be some problems that have been caused by that——

Mr. OWEN. They have some capital problems.

Chairman STARK. That is right, but on balance, their hospital rates are the lowest in the country and California's are the highest, and California has been sort of laissez-faire. I am saying I am not sure that either State has the proper answer, but it looks like somewhere in between, as has been suggested, might be the answer—which might mean some more regulation.

I don't think there is any quarrel over the fact that the present system is not working, but it would be very helpful to this committee—and I suspect that someday, we will prevail—to have more precise information on a hospital-by-hospital basis. Because we are dealing here with people who all have hospitals in their district, which is going to make an impression on voting members, and I think that we could do a better job with better information. And I would like to see the American Hospital Association in the vanguard of enlightenment and management science. If they can provide the finest medical care on the face of the globe, why not find us the management tools?

Mr. OWEN. We think we do.

Chairman STARK. I suspect that based on their inability, supposed inability, to provide data, that they are way behind all the other industries in this country who provide us data. The railroads provide us better data than the hospitals. Think about that one for a minute.

Mr. OWEN. I think the record will show that we have provided you with data in your committees whenever we could, on the basis of what is proprietary and what is not from the standpoint of the hospitals themselves.

Chairman STARK. There is no such thing when you are asking for Federal dollars, my friend, as proprietary. That is when, as I say, if you do not like the system, you can drop out. I think that the idea that there is some secret competitive data that hospitals ought not to divulge won't stand up.

Mr. OWEN. I think the basic problem, though, is that it is not that no one wants to divulge it or let it go; it is just as you said earlier, you had some concern about the lack of trust, I guess. And I think there is a lack of trust in what has happened in this program well before you became chairman of the subcommittee. It started out in one fashion, and we hadn't even gone a year, and it was changed. There is a feeling by hospitals that all you really want data for—not you, personally, but all Congress wants data for—is so they can take out more money to offset the budget deficits on the other side, and we are left with a patient who is lying in the hallway or who is bleeding and needs to be taken care of. That is a legitimate, I think, reason for being very cautious. If you want more data, then let's see something that indicates that we will be recognized for it, not rewarded for it, but recognized for it. It hasn't happened.

And as I say, I will continue to work with you——

Chairman STARK. I suspect that is the concern, and if we were not providing the funds, that concern would not bother me. But when we are constantly pressured by the same folks for more money—and you have seen the letters in my office, mostly from California hospitals, they just lie. They tell us they are going broke. And you and I both know that is just an unvarnished fabrication.

So, you go in the same door you come out. They are concerned that we may use this data to cut funds. We are concerned that they may, in the most unconscionable way, use the data to create and fabricate situations which do not exist, as an effort to get more of the taxpayer's dollar. I am not so sure that either one is proper. We can argue about what the data mean, but we ought to be working off the same numbers. That is an easy one.

Mr. OWEN. But you do get more data from California than almost anywhere else.

Chairman STARK. That's right, but not from the California Hospital Association. It is because of a law in California that requires that I can get the data from the comptroller of the State, not from the hospitals.

Thanks very much for being with us today.

Mr. OWEN. Thank you, and I will continue to work with you, and provide whatever data I can give you.

[The statement of Mr. Jack W. Owen follows:]

American Hospital Association

AHA

Capitol Place, Building #3
50 F Street, N.W.
Suite 1100
Washington, D.C. 20001
Telephone 202.638-1100
Cable Address: Amerhosp

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
OF THE
U. S. HOUSE OF REPRESENTATVES
ON
THE STATUS OF THE MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM

March 1, 1988

SUMMARY

Hospitals remain strongly committed to the Prospective Payment System despite the unpredictability of payment levels due to numerous and frequent changes in payment policy. To help ensure that the goals of PPS are met, a moratorium on further reductions in Medicare hospital payments is necessary so that policymakers can better understand the impact of changes already made.

Although hospital productivity and efficiency have improved, hospital costs have increased chiefly because of greater average patient acuity and the rising cost of resources, particularly labor.

To address inequities in PPS, the American Hospital Association recommends adoption of a single, base rate applicable to all hospitals, adjusted for differences among hospitals in the types of patients treated, and for local differences in resource prices.

Mr. Chairman, I am Jack W. Owen, Executive Vice President of the American Hospital Association and director of its Washington office. The AHA represents more than 5,600 member institutions and nearly 45,000 personal members. I am pleased to have this opportunity to comment on the status of the Medicare hospital Prospective Payment System (PPS).

Although the adoption of prospective pricing by Medicare was the most fundamental change in the Medicare program since its enactment in 1965, it was accomplished with relatively little controversy. Both the Medicare program and hospitals strongly supported adoption of the new payment system, although proposals put forward by Medicare and hospitals differed in several ways. The five years that have elapsed since the enactment of the program have seen substantially greater controversy over appropriate payment levels and the issue of equity.

Despite the controversy, hospitals remain firmly committed to the new payment system. Prospective payment offers benefits to Medicare beneficiaries in the form of a fiscally secure program and access to state-of-the-art medical treatment, to the Medicare program in the form of more predictable outlays and greater confidence that services are being purchased prudently, and to hospitals in the form of positive incentives that reward efficiency and allow the delivery of high-quality care to the beneficiaries and the communities they serve. Realizing those benefits, however, requires Congress, the Administration and hospitals to grapple with a number of difficult issues. Above all, it requires a commitment to let the incentives inherent in prospective pricing work.

And it requires predictability--a critical feature of prospective pricing that has been conspicuously absent during the past few years. Not only have

Medicare payment policies changed frequently, the changes also have been decided upon and implemented months after the start of both the federal and hospital fiscal years to which they apply. A brief review of the past few years' reconciliation bills makes this obvious:

- In FY 1985, the Deficit Reduction Act (DEFRA) reduced the update in prices that was called for by the legislation creating PPS from "marketbasket plus one percent" to "marketbasket plus one-quarter of one percent."
- In FY 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA), enacted on April 7, 1986, six months after the start of FY 1986, made several changes in the payment formula and increased prices by 0.5 percent.
- In FY 1987, the Omnibus Budget Reconciliation Act of 1986 (OBRA 86), enacted on Oct. 21, 1987, nearly a month after the start of FY 1987, again made several changes in the payment formula, and increased prices by 1.15 percent.
- In FY 1988, the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), enacted on December 22, 1987, nearly three months after the start of FY 1988, once again made numerous changes in the payment formula.

Even though changes to PPS are inevitable, and many have been supported by hospitals, they can be problematic because they weaken the basic foundation of prospective pricing: the incentive to improve efficiency through effective planning and management. Uncertainties over the annual update factors and payment policies make it virtually impossible for a hospital to project its financial performance and plan changes in its services. For example, a hospital with a fiscal year beginning on July 1, 1987, was forced to develop its budget without knowing what it would be paid by Medicare. In fact, during its current fiscal year, the "prospectively" set prices it will receive from Medicare will have changed four times:

- On July 1, 1987, when it started its fourth year under PPS;
- On October 1, 1987, when regulatory changes proposed by HCFA went into effect;
- On November 21, 1987, when the Gramm-Rudman sequestration took effect; and
- On April 1, 1988, when the provisions of the Omnibus Budget Reconciliation Act of 1987 took effect.

In addition to coping with the changes in PPS, hospitals also are attempting to absorb other significant changes in Medicare payment policies. Over the past five years, the annual budget reconciliation acts have included hundreds of provisions affecting Medicare, leaving a patchwork of policies in place. For example, by October 1 of this year, a single outpatient encounter between a Medicare beneficiary and a hospital may involve the application of as many as four different payment rules: detailed fee-schedules for clinical laboratory services; a mixture of "global" fees and costs for "surgical" procedures; a mixture of detailed fee schedules and costs for outpatient radiology procedures; and costs for "other" outpatient services.

The net effect of the Medicare payment policy changes, some of which will not go into effect until next year, has been a significant reduction in hospital payments. The impact of these changes on the ability of hospitals to continue delivering high-quality, state-of-the-art care to Medicare beneficiaries and the communities they serve is unknown at the present time and will require several months to determine. As a result, it is time to declare a moratorium on further cuts in Medicare payments. A moratorium would give Congress, HHS, and hospitals needed time to examine the impact of the changes that already have been made, to assess what further actions are necessary to ensure continued access for beneficiaries, and to address problems with current policies.

ADEQUACY OF PAYMENT

Each year, controversy rages over the appropriate amount by which to increase prices under PPS. At the root of this controversy are basic questions concerning the appropriate method of setting prices, and the size of and justification for Medicare "operating margins." The AHA initially adopted a position that called for a simple "marketbasket" updating formula, believing that it was inappropriate to tie payment to costs. Congress and the Administration have rejected that approach to setting prices, based on the rationale that operating margins should be limited to a "reasonable" level. Congress now should acknowledge explicitly the policy that has implicitly guided the setting of the annual update amount, specifically that prices bear a "reasonable" relationship to costs.

Despite the magnitude of the cuts that already have been made over the past several years, some policymakers continue to advocate further reductions. In the past two years, these challenges have relied on data concerning Medicare operating margins. Recently, as operating margins have declined, the focus has shifted to the rate of increase in Medicare costs.

The AHA believes that the increase in costs is the result of several factors and has occurred despite recent improvements in hospital productivity and efficiency.

- First, the increase in costs appears to be related to the reported increase in the "case-mix index"--an indicator of patient acuity. One of the intended outcomes of PPS has been to treat less acutely ill patients in the outpatient setting. As a result, hospital inpatients are more seriously ill, on average, and therefore require more costly care.

- Second, the marketbasket used by HCFA appears to understate the impact of inflation on costs, chiefly because it gives little weight to changes in wage levels among hospital employees. The growing shortage of nurses and other health professionals has demonstrated the need to pay more to attract and retain high-quality personnel. Because labor accounts for more than 75 percent of the operating costs of a hospital, the HCFA marketbasket substantially understates the impact of necessary wage increases on hospital costs.

- Third, at least a part of the increase in Medicare operating costs between the first and third years under prospective pricing is attributable to problems with the first year Medicare cost reports, which understated the cost of treating Medicare patients. These problems also are responsible for the overstatement of operating margins in the first two years of PPS.

- Fourth, after declining rapidly in 1984 and 1985, length of stay leveled off. Recently, however, it has edged up slightly. This slight upward trend should not be surprising, as length of stay would be expected to rise with a decrease in short-stay admissions.

These considerations lead the AHA to believe that the change in costs is attributable to changes in the types of patients that are being admitted to hospitals and to changes in what hospitals must pay for resources, particularly labor. For these reasons, the AHA believes that no further changes should be implemented until a concerted effort has been made to evaluate the impact of existing cuts and to establish all the facts behind the recent increase in costs. In light of this, the AHA would support the updating of prices for FY 1989 by the amounts called for in OBRA 1987.

EQUITY ISSUES

The effort to ensure equitable payment under PPS has caused nearly as much controversy as the effort to establish an "appropriate" level of payment. Payment inequitiesa threaten the ability of individual hospitals to continue meeting the needs of the Medicare patients they serve, and the overall adequacy of funding. To some extent, the operating margins that have been reported may be the result of inequities in the system. Hospitals may earn a margin because they are efficient or because they benefit from an inequity, just as a hospital may incur deficits because of inefficiency or because it bears the cost of an inequity.

Unfortunately, there is no simple solution to the equity problem. It is not possible to mitigate inequities by adopting a "Robin Hood" approach that would take money from hospitals with positive margins and give it to those with negative margins without destroying the incentives of prospective pricing. Instead, a sustained and significant effort must be mounted to address the underlying sources of the major inequities. To that end, the AHA has developed the following recommendations, and is prepared to work with the Congress and HCFA to implement them.

- The AHA recommends adoption of a single base rate, applicable to all hospitals and adjusted for differences among hospitals in the types of patients treated, including the indirect medical education and disproportionate-share adjustments, and for local differences in resource prices. During the period required to implement this proposal, hospitals must be held harmless against further cuts.

- A severity-of-illness adjustment should be implemented as soon as possible. Action is needed now to ensure the eventual implementation of such an adjustment. Congress has directed the Secretary to report to Congress on a legislative proposal to account for variations in severity of illness by Oct. 21, 1988.

- To address the limitations of current resource price adjustments, Congress should direct the Secretary to develop criteria for making adjustments to PPS prices for local labor prices that are not adequately captured by the current area-wage index and for non-labor input prices. Eventually, improved resource price adjustments should be incorporated into PPS, thus reducing the need for area-by-area fine-tuning of the system.

- Because prospective pricing relies on the law of averages, which may not be applicable in small hospitals serving isolated communities, the losses of hospitals located in such areas should be limited according to a formula that reimburses a percentage of the difference between PPS revenues and costs based on volume.

- The designation of all existing rural referral hospitals should be extended for an additional five years, or until the dual urban/rural rate structure is eliminated.

- Both urban and rural hospitals should be allowed to provide all levels of care, not simply acute inpatient hospital care. By allowing hospitals to provide skilled nursing care to Medicare beneficiaries for limited periods of time, the quality and continuity of care would be increased, and the current bed capacity would be put to fuller use.

- The periodic interim payment program should, at a minimum, be maintained for all hospitals now eligible.

CONCLUSION

Although the AHA contends that many of these recommendations for adjusting PPS are necessary today, the need to evaluate the impact of previously enacted changes in policies is so great that a delay in implementing the recommendations would be appropriate, provided there is a moratorium on further payment cuts. Such a delay also would allow the work needed to implement several of the adjustments to proceed as rapidly as possible.

Chairman **Stark**. I would like to, without any prejudice in the order in which I am suggesting this, make a part of the record some statements which we have received; people have submitted them and asked them to be put in the record.

I would say for the record that in the opinion of the Chair, the statement which I have received from my colleagues in California deserves attention. It is a statement submitted by some of my California colleagues on the plight of California hospitals.

Another statement is from a former Member, Mr. Roosevelt, that I think should be ignored by all reasonable people, and I would submit that those people who have been hoodwinked into contributing to his organization ought to read it and take it with a grain of salt, but we will put it in the record anyway.

The committee stands adjourned.

[Whereupon, at 12:40 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF
TOMMY R. MCDOUGAL
PRESIDENT
ALABAMA HOSPITAL ASSOCIATION

I am Tommy R. McDougal, President of the Alabama Hospital Association (AlaHA). On behalf of the 145 member hospitals and 302 personal members of AlaHA, I appreciate the opportunity to submit for the record the Association's comments on the status of the Medicare hospital prospective payment system (PPS) and particularly how it relates to the hospitals in the state of Alabama.

While the Association is encouraged by the recently approved changes in the Medicare prospective payment system, we regard the changes as only the first steps toward substantive relief for hospitals, particularly small, rural ones, many of which are experiencing severe financial difficulties.

The net effect of Medicare policy changes over the last few years has been a significant reduction in hospital payments. The impact of these changes on the ability of Alabama hospitals to continue delivering high-quality health care to our Medicare beneficiaries and the communities they serve is difficult to assess at the present time; indications are however, that a crisis is looming if cuts in federal funding continue.

MEDICARE PROSPECTIVE PAYMENT SYSTEM AND DEFICIT REDUCTION

Congress's concern with the growing federal deficit problem has become the overriding influence on domestic policy decisions, particularly those made with regard to the Medicare program. During the last several federal budget cycles, the Congressional authorizing committees with jurisdiction over Medicare have consistently looked to the Medicare program, and in particular to hospitals, as a major source of achieving budget savings required to meet budget deficit targets.

Medicare has traditionally contributed disproportionately to deficit reduction, with projected spending having been cut more than $25 billion since 1981. Medicare, accounts for only 8% of the federal outlays, yet it constituted 24.6% of total cuts in the White House FY88 budget proposal. The FY88 budget law (OBRA(87), P.L. 100-203) enacted by Congress, cuts Medicare program spending by $2.1 billion in FY88 and $3.8 billion in FY89, with most of the savings coming from reducing or capping payments to hospitals and physicians.

With PPS now in it's fifth year, the transition to national rates is complete. Now all hospitals will be playing by the same rules, giving a truer reading of an individual hospital's level of efficiency. The way it was set up in the past, Alabama hospitals - which, historically, have ranked among the lowest in the nation for cost per admission, cost per inpatient day and length of stay - were penalized, while hospitals which provided high-cost healthcare were rewarded.

During each of the past five years, Congress has passed legislation to set the annual update factor, and these measures have become the focus of hospital efforts to ensure payment adequacy. Since PPS' inception, the hospital industry has advocated annual PPS price increases equaling the rate of increase in the hospital marketbasket of goods and services until better measures of illness severity, labor expenses, and other resources are available.

Payment increases based on these recommenations have not been forthcoming. In fact, the annual updates over the past five years have totaled only 9.7% while the hospital marketbasket has increased 19.5%. Additionally, a 1% cut in PPS and exempt-facility payments was imposed under the Gramm-Rudman-Hollings deficit reduction law in 1986, and in 1987 a 2.3% reduction was suffered beginning November 21, effectively reducing the FY88 udate to 0.4%.

Not only have Medicare payment policies changed frequently over the past few years, the changes have been decided upon and implemented months after the start of both the federal and hospital fiscal years to which they apply. Uncertainties over the annual update factors and payment policies make it virtually impossible for a hospital to project its financial performance and plan changes in its services. Predictability is paramount to the future viability of the health care system.

HOSPITAL OPERATING MARGINS

Reductions in the growth of hospitals' full time equivalent employees, shorter lengths of stay, and fewer inpatient admissions have for the most part resulted in sizeable savings to the Medicare program. However, many of those reductions, particularly those related to jobs and wages, are a one time phenomenon. They cannot be duplicated every year to produce the amount of savings achieved during the early phases of PPS without jeopardizing quality of care.

Nonetheless, the perception persists among federal policy makers that hospital operating margins during PPS' second and third years were excessive.

Federal policymakers increasingly are relying on hospital cost and operating margin data to set annual update factors. The Department of Health and Human Services' (HHS) Inspector General (IG), using methodology severely criticized by hospitals, calculated hospital operating margins of between 12% and 14% in PPS' second year and between 8% and 10% the third year. On the other hand, preliminary industry data indicate 34% of hospitals had a negative operating margin for Medicare services in FY86. And in correspondence to the White House last year, HHS Secretary Otis Bowen, M.D., wrote that even if a 1.5% Medicare price increase had been granted hospitals in FY88, 40% of those institutions would suffer losses on Medicare inpatient care.

Analysis by the Prospective Payment Assessment Commission (PROPAC) reveals that hospital Medicare profits have dropped from 14% of revenues in 1984 and 1985 to 8.2% in 1986. PROPAC estimates that the average PPS operating margin probably fell in 1987 to about 2% and predicts that the average margin for 1988 will fall below zero.

The institutions which compose the Alabama Hospital Association are very concerned about the findings contained in these operating margin reports. The profit margins reported are certainly not true for Alabama hospitals in 1986. Information provided to the Association by 96% (119 hospitals) of our state's acute care hospitals clearly dispute the IG's figures. In fact, 1986 Medicare cost reports show that the net income from all patients in Alabama hospitals was only 2% of net patient revenue. Sixty percent of our hospitals experienced a net loss in patient revenues in 1986. Only 48 of the 119 reporting hospitals experienced an operating profit.

If the IG profit information held true for our hospitals, then Alabama hospitals would have had to incur a loss on all non-Medicare business. Clearly the concept of losing money on the 66 percent of non-Medicare business which, except for Medicaid, generally pays at a higher rate than Medicare, is unreasonable.

What we find even more frightening than the information above is the fact that NONE of Alabama's hospitals with less than 51 beds earned a profit in 1986. They averaged having only 3 days of cash on hand and could pay only 5/100 of their current liabilities on the last day of their fiscal year. The picture for hospitals having 51 through 100 beds was not much better and is certainly different from that painted by the Inspector General. Thirty-eight of Alabama's 67 counties are served by hospitals with less than 100 beds.

Sixty-four of Alabama's 123 acute care community hospitals with less than 100 beds serve over one half of the state's counties. Seventy-five percent of these hospitals reported net losses in 1986 and 17% reported negative patient revenues in 1986.

There are currently 32 acute care general hospitals with less than 51 beds in Alabama, which employ approximately 2300 people. These facilities have an economic impact of about $570 million yearly. In many cases these facilities are the largest businesses in the community, and are the only healthcare alternative for many community citizens. To close them will create a devastating community impact. In addition to the unfavorable economic impact, hospital care will be restricted to those who can await treatment while being transported to another facility. Without the timely care provided by community hospitals many people will suffer unnecessarily.

The costs of the goods and services hospitals buy will have increased almost 32% from 1983 to 1989. By contrast, the Medicare update factor will have increased only 13%. If price increases lag almost 19 percentage points behind increases in the cost of what hospitals must buy to provide care, there is simply no way that most hospitals can generate the modestly positive margin they need to provide the quality of care that Medicare beneficiaries deserve.

Between 1982 and 1987, five Alabama hospitals closed. Up to twice that number are at risk of closing this year alone. Because of it's financial situation, during the first two months of 1988, one hospital has already closed.

FACTORS CONTRIBUTING TO INCREASED HOSPITAL COSTS

While Medicare payments have been tightened in recent years, another reason for declining margins is a dramatic increase in costs per case. National data reveal that inpatient costs in 1987 have increased by 8.1%.

Of that, 6.3% went to goods and services that hospitals buy (excluding capital and malpractice) and 1.8% went to the volume of services.

Overall, the increase in costs is due partly to the fact that hospital admissions have dropped and hospitals are treating fewer inpatients. As a result, the percentage of hospital beds that are empty is increasing. In addition, since the simplest cases are no longer being admitted to the hospital, the cases that remain in the hospital are, on average, sicker than before.

In addition, dramatic shifts in site of treatment have raised related hospital costs, particulary as skilled staff are needed to treat the increasingly older and more severely ill Medicare population. New technology and procedures are in demand. While these advances may result in better outcomes with less risk to the patient, the associated costs inevitably lead to higher hospital expenses. Finally, uncompensated care costs continue to rise.

Technology is an increasingly expensive component of the hospital budget. Unlike other industries where the consumer can wait for the latest technological advance until it is affordable, hospitals cannot wait for the latest diagnostic or therapeutic tool. Maintaining the highest quality health care requires constantly updating equipment and personnel skills.

Historically, Alabamians have demanded the latest and best in accessible, quality health care. Hospitals have accepted this challenge, offering the citizens of Alabama the best health care available. While these hospitals are dedicated to providing this care, today they are faced with strong, new incentives to control rising health care costs, skyrocketing personnel costs and increasingly expensive technology. Coupled with the Medicare prospective payment system and declining patient days, hospitals are facing their greatest challenge - to reduce the rate of increase for health care costs while continuing to provide quality of care, and many hospitals will not survive.

Taking the initiative, hospitals all over Alabama have aggressively intensifed their efforts to become more cost-efficient while continuing to be responsive to patient's needs. Today, hospitals are sharing expensive equipment, pooling resources, increasing outpatient services and encouraging healthy lifestyles, among other activities. Hospitals are trying to control costs through group purchasing, sharing equipment or personnel, outpatient services, home health services, etc. Despite these efforts costs are still rising.

Per patient day costs of care in Alabama hospitals are as follows: actual costs are $540.77; reimbursement from all sources is $552.46; which results in a margin of $11.69. The picture is different for small/rural hospitals (those with less than 100 beds) in Alabama. Actual per patient day costs of care are $441.59; reimbursement from all sources is $418.69; which results in a deficit of $22.90.

Highly skilled personnel are essential to the hospitals in Alabama. Almost 50% of Alabama hospital budgets are spent on wages and employee benefits. Data from Alabama hospitals reveal that budgets are composed primarily of: salaries 41.5%; benefits 7.6%; general operating expenses 50.9%. Alabama hospitals employ over 60,000 health care workers. Small/rural hospitals employ over 8,400 health care workers. As an industry, Alabama hospital expenditures for 1986 were $2.2 billion.

Another major cost factor for the hospitals in Alabama is the delivery of uncompensated care (non-payment for medical services rendered). Simply put, uncompensated care is reaping havoc on Alabama hospitals' financial health. In 1986 alone, hospitals collectively absorbed over $260 million worth of uncompensated care at actual costs, or more than 12% of their total expenses.

Moreover, the uncompensated care crisis is particularly critical for small/rural hospitals because they generally treat a high percentage of indigent and elderly patients who receive benefits from Medicaid and Medicare. The percentage of small/rural hospital patients on Medicare is 38%, while 49% of their total patient days are for Medicare patients. Medicaid patients make up about 10% of total small/rural patients, and have an average length of stay of 3.4 days.

One significant part of hospitals' operating budget and which has a direct impact on access and ability to render care is the cost of recruiting and retaining qualified nursing personnel. As the elderly make up a greater percentage of the nation's population, and as the severity of illness of both hospital patients and those in post-acute care settings increase, the demand for more highly skilled nurses has risen accordingly. As federal and state lawmakers try to alleviate the problem, hospitals are doing their best to cope with the shortage without disruption of patient care.

Continued and increased federal funding of nursing education, both at entry-level and for advanced degrees, is an essential step in addressing the problem. But simply providing education funds is insufficient if hosptials are not adequately reimbursed for the care they deliver, thus enabling them to pay competitive salaries. The federal government must pay providers adequately under Medicare and insist on adequate Medicaid reimbursement, as well as find ways to address the growing problems of the uninsured, the under-insured population, and the AIDS patients.

The hospitals in Alabama are becoming increasingly concerned about the many issues related to AIDS, particularly as the progression of the AIDS epidemic is escalating at such a steady pace. In 1986, through the month of April, there were 11 total AIDS cases in Alabama. In 1987 through April there were 48 total cases. By mid-July, 1987, the number increased to 74 cases. As of 8-21-87, the State Department of Public Health had identified 157 cases since 1982. By the end of 1987, it was projected that Alabama could have its AIDS cases double in number every 12 months. Based on this projection, by the end of 1991, Alabama will have 2,893 AIDS cases. The costs of caring for these patients alone could overburden the state's entire health care system.

AIDS care costs are draining many public hospitals, particularly in the South according to a survey conducted by the National Association of Public Hospitals of 169 public and teaching hospitals. In 1985, hosptials spent $380 million $20,320 per patient on AIDS care. Southern hospitals are losing almost twice as much money on care for AIDS patients as facilities in other regions of the country; southern hospitals' AIDS losses average $9,000 per case, nearly double the national average. The study links the regional difference to lower Medicaid reimbursement and a greater amount of charity care provided at Southern hospitals.

Adequate funding is severely needed by hospitals for costs associated with the care of AIDS patients, including staffing, research, aquisition of equipment, renovation of facilities, and education, training, and services related to providing such care.

CONCLUSION

Although hospital productivity and efficiency have improved, hospitals costs have increased chiefly because of greater average patient acuity and the rising cost of resources, particularly labor. Dramatic shifts in site of treatment have also raised related hospital costs, as have new technology and procedures. While these advances may result in better outcomes with less risk to the patient, the associated costs inevitably lead to higher hospital expenses. Also, uncompensated care costs continue to rise.

The impact of these factors on hospitals' ability to continue to deliver high-quality health care is demonstrated by reports of falling hospital operating margins. Access and quality concerns are increasing, but hospitals cannot continue to deliver high quality services unless they can depend on adequate and predictable Medicare payments.

Finally, hospitals have contributed more than their fair share toward Federal deficit reduction. Further cuts in PPS payments would adversely impact quality and access to care for millions of Americans.

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

RE: Hospitals and the Medicare Prospective Pricing System

March 28, 1988

In 1983, Congress enacted the Medicare prospective pricing system (PPS) under which hospitals are paid a fixed amount based on the patient's diagnosis. The enabling law authorizes the diagnosis related group (DRG) prices to be increased each year by a marketbasket index that reflects annual increases in hospitals' costs of goods and services plus an increase for intensity of services and new technology. Since the enactment of the DRG system, however, Medicare payments to hospitals have not even kept pace with increases in the marketbasket index. Instead, arbitrary payment reductions have been enacted to achieve budgetary savings.

The AMA is very concerned over the adverse impact that continued inadequate Medicare payments could have on the quality of and access to care for Medicare beneficiaries and other patients. Continuation of inadequate updates in hospital reimbursement can be expected to result in -

- o limitations on the acquisition of expensive but essential medical technology;
- o cutbacks in the use of labor intensive services; and
- o the closing of more community hospitals, particularly small rural hospitals.

We are also concerned over the cuts in direct and indirect medical education funding set forth in the Administration's FY89 budget proposal. These cuts could have a serious adverse impact on teaching hospitals' ability to provide quality care.

Hospital Profitability

A recent Office of Inspector General (OIG) report shows that hospitals' Medicare earnings decreased significantly in 1986. The report states that in fiscal year (FY) 1984, the first year under the PPS, earnings for the over 7,000 Medicare participating hospitals were about $4.6 billion. In FY85 hospitals earned an estimated $4.9 billion, and in FY86 earnings fell sharply to an estimated $3.6 billion. The OIG analysis also indicates that the average PPS profit margin decreased to 9.5 percent in FY86, compared to 14.4 percent in FY85 and 14.2 percent in FY84. Significantly, 35 percent of the hospitals included in the OIG sample incurred PPS losses in FY86 compared to only 20 percent in FY85.

Rural hospitals were particularly hard hit. While urban hospitals had an average profit margin of 10.8 percent in FY86, rural hospitals experienced an average loss of 0.69 percent. Moreover, while 78 percent of urban hospitals had Medicare earnings (down from 91% in FY85), only 39 percent of rural hospitals exceeded expenses on their Medicare patients (down dramatically from 61 percent in FY85).

The reason for the significant decrease in hospital Medicare earnings is that hospitals' revenue from Medicare is not keeping pace with their increased costs. According to the American Hospital Association (AHA), during fiscal years 1984 - 1987 the Medicare update factor increased by only 9 percent while inflation in the hospital marketbasket of goods and services was 18.4 percent. In addition, HCFA has been slow in updating the DRGs to take into account new medical technologies, including such major advances as TPA and extracoporeal shock wave lithotripsy.

The trend of reduced hospital earnings is likely to continue in light of the small increases in the Medicare update factor for FY87 and FY88. (In FY87, the update factor was only 1.15 percent. For FY88 the factor is 1.5 percent in large urban areas, 1 percent in other urban areas and 3 percent in rural areas.) In fact, the Prospective Payment Assessment Commission (ProPAC) estimates that the average PPS hospital margin fell to 2 percent in FY87 and may fall to below zero in FY88.

Factors Contributing to Increases in Hospital Costs

During the first few years of the PPS, most hospitals were able to realize Medicare earnings by improving their efficiency and productivity. Rewarding efficient hospitals was, in fact, one of the stated goals of the switch to fixed payments per discharge. Measures adopted include a reduction in hospital workforces, reduced lengths of stay, and fewer inpatient admissions. In our view, hospitals have succeeded in cutting most of the "fat" from their operations. For a number of legitimate reasons, however, hospitals' costs have continued to rise.

An important element contributing to increased hospital costs is the severe shortage of bedside nurses. Because of the growing number of elderly patients who tend to be more seriously ill, the demand for bedside nursing services is rising rapidly. At the same time, the number of newly trained nurses is decreasing. The resulting shortage is forcing hospitals to pay larger salaries to attract and keep qualified nurses. The Federation of American Health Systems estimates that nursing costs are expected to rise by 8 percent or more this year.

A second key reason for hospitals' increased costs is the growing demand for and use of important new medical technologies, including magnetic resonance imaging and implantable defibrillators. These technologies result in higher quality patient care but, at the same time, can significantly increase hospital costs.

Declining hospital admissions are another major factor contributing to higher inpatient hospital costs, as many medical procedures are being shifted to the outpatient setting. According to the AHA, the number of hospital admissions declined from 33 million in 1985 to 32 million in 1986. At the same time, 13 million more outpatients were cared for in 1986 than in 1985. The result of the shift of many routine procedures to the outpatient setting is that patients who are hospitalized tend to be more seriously ill and thus require more intensive and costly treatment. This is reflected in the fact that, according to the OIG, the average Medicare cost per discharge increased by about 6 percent in FY86.

The fourth major reason contributing to increased hospital expenses is the rising cost of providing indigent care. According to the AHA, hospitals provided $7 billion in uncompensated care in 1986, up 151 percent from 1980. At the same time, most private purchasers of health care are now refusing to subsidize care for the indigent. Thus hospitals are forced to absorb these costs.

The final significant factor in hospitals' increased costs is the rise in medical malpractice expenses. According to a 1986 General Accounting Office report, total malpractice insurance costs for hospitals increased by about 57 percent, from $849 million in 1983 to $1.33 billion in 1985. This increase was much greater than the percentage increase in total hospital expenses.

AMA Concerns and Recommendations

The AMA is very concerned over the impact that continued inadequate Medicare payments will have on the quality of and access to care for Medicare beneficiaries and other patients. Continuation of inadequate updates in hospital reimbursement will likely result in cutbacks in the use of labor intensive services and expensive but essential medical technology and procedures - adversely affecting patient care, and resulting in the closing of more community hospitals. In 1986 alone, 71 community hospitals closed, almost double the average of 36 annual closures that occurred between 1980 and 1985. More than half were rural facilities and 83 percent were hospitals with 100 or fewer beds.

The AMA supports the recommendation of the Prospective Payment Assessment Commission (ProPAC), which has urged that the PPS update factor for FY89 be set at 3.8 percent for urban hospitals and 4.6 percent for rural hospitals. We recognize that ProPAC's recommendation is greater than the increase mandated by Congress in the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203). In that Act, Congress set the PPS update factor for FY89 at the marketbasket (currently estimated at 5.1 percent) minus 1.5 percent for rural hospitals, the marketbasket minus 2 percent for hospitals in urban areas of greater than 1 million persons, and the marketbasket minus 2.5 percent in urban areas of less than 1 million persons. In our view, Congress should follow the recommendations of ProPAC, the expert panel established by Congress to recommend appropriate updates in the PPS. Adequate hospital reimbursement is essential to ensure that Medicare beneficiaries continue to receive high quality care.

FY89 Budget Proposals

The AMA urges Congress to reject the proposed cuts in direct and indirect medical education funding set forth in the Administration's FY89 budget proposal. Of particular concern is the Administration's proposal to cut the indirect medical education (IME) adjustment from 8.1 percent to 4.05 percent. In P.L. 100-203, Congress already decreased the IME adjustment to 7.7 percent for FY89. A further significant reduction could have a serious adverse impact on teaching hospitals' ability to provide quality patient care. In our view, an IME adjustment of approximately 8 percent accurately reflects hospitals' increased costs for treating the generally more severe needs of patients in these hospitals and for training residents.

The AMA is also concerned over the proposal to limit reimbursement of hospitals' direct medical education costs to residents' salaries and fringe benefits and appropriately allocated overhead. Under this proposal, program costs such as classroom space and supervision by teaching physicians would no longer be reimbursed. Legitimate direct medical education costs incurred for classroom space and supervision by teaching physicians should not be ignored in determining the fair share of such expenses to be borne by Medicare.

Conclusion

The AMA is greatly concerned that inadequate Medicare payments could jeopardize the ability of hospitals, particularly those in rural areas, to provide quality patient care to Medicare and non-Medicare patients. Hospitals' Medicare earnings decreased significantly from 1985 to 1986. Further reductions are likely because the FY87 and FY88 PPS payment rate increases have not kept pace with rising hospital costs. The lack of adequate payments could force hospitals to reduce access to important services including expensive medical technology, thereby adversely affecting the quality of patient care. Moreover, many more hospitals could close and further jeopardize access to health care services.

In order to help ensure that hospitals have the resources to continue to provide quality patient care, we urge Congress to adopt ProPAC's recommendations that the PPS update factor for FY89 be set at 3.8 percent for urban hospitals and 4.6 percent for rural hospitals. We also urge Congress to reject the Administration's graduate medical education budget proposals. These proposals could significantly affect the ability of teaching hospitals to provide quality patient care.

The AMA also believes that Congress should consider the need for long-range Medicare reform, so that the promises made by previous Congresses of access to quality health care services for our nation's elderly and disabled will be met. We have developed a realistic proposal for reform of the Medicare program that will stabilize financing, generate savings, and assure the continuation of health care coverage for all of the coming generations of our nation's elderly. Our proposal deserves serious consideration. (A booklet summarizing the AMA's proposal is attached to this statement.)

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

TO

THE SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

FOR THE RECORD OF THE MARCH 1, 1988 HEARING ON

THE STATUS OF THE MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM

A Survey of Internists' Experiences Under DRGs

Medicare pricing for inpatient hospital care since October 1983 has been done prospectively, based on diagnosis-related groups (DRGs). The advantage of this payment method is that it provides incentives for both physicians and hospitals to care more efficiently for patients. A major concern with the prospective payment system (PPS), however, is that it can pressure health care providers to skimp on necessary medical services when caring for the elderly in order to minimize hospitals' expenses.

To assess internists' attitudes toward the effects of PPS -- both positive and negative -- the American Society of Internal Medicine (ASIM) scientifically surveyed its members' experiences with the DRG program. (The survey methodology is discussed at the end of this report and a copy of the survey is appended.) Specifically, the survey had the following objectives:

- Determine whether ASIM members think the overall quality of hospital patient care has improved or diminished as a result of the prospective payment system.
- Assess attitudes concerning the positive and negative effects of diagnosis-related groups.
- Determine whether physicians are experiencing pressure to alter their practices as a result of DRGs; and if so, examine the manner in which that pressure is exerted.
- Test reaction toward peer review organizations (PROs) and find out whether physicians are experiencing pressure from their PROs to alter the way in which they practice.
- Evaluate opinions regarding discharge planning for Medicare patients needing post-hospital care and ascertain whether the DRG system has created a need for nursing home or home health care that is not being met.
- Gather anecdotal information on the effects of the DRG system.

Results from the 648 internists who responded to the survey reveal widespread concern about the quality of medical care under PPS. Although prospective payment has heightened physician consciousness over the cost of health care, leading to fewer unnecessary admissions and a decrease in unnecessary tests and procedures, internists believe that PPS also has resulted in diminished hospital services, premature discharges, delayed admission of patients needing hospitalization and other negative effects. Further, although hospitals are perceived as providing adequate discharge planning for patients under PPS, internists feel that the emphasis on discharging patients as early as possible has created a need for nursing or home health care than many communities have not been able to meet. Finally, the survey indicates that PROs -- the organizations established to review both the utilization and quality of health care -- are the most responsible for influencing physicians to alter their practice patterns inappropriately.

QUALITY OF CARE

The primary objective of the ASIM survey was to find how internists assess the effects of PPS on the quality of patient care. Two-thirds of the respondents (65 percent) indicated that prospective payment has either "somewhat diminished" (53 percent) or "considerably diminished" (12 percent) the quality of patient care. Thirty-one percent of those physicians surveyed believed that there has been no overall change in the quality of care under PPS. Only 4 percent of the respondents felt that PPS had either "somewhat improved" (3 percent) or "considerably improved" (1 percent) patient care.

Physician concern over the quality of medical care is clearly reflected in their comments. One internist noted that there has been a **"definite swing to viewing patients as monetary units rather than people who need care."** Another doctor wrote, **"Medicare patients are universally 'sicker' by the time they are hospitalized compared to the pre-DRG era."** These concerns with health care costs and medical utilization have been perceived by many patients as lower-quality care. One internist reported that **"families are angry that I am no longer practicing the 'art' of medicine in caring for the elderly. They see early discharges as dumping and lack of caring."**
The widespread perception that PPS has hurt the quality of patient care is shared by a large majority of all ASIM subgroups: rural and urban physicians; specialists and subspecialists; doctors practicing at large and small hospitals; physicians in different geographic regions (Northeast, South, Midwest and West); and physicians with large and small Medicare patient loads. For example, 66 percent of the physicians practicing at urban hospitals said that PPS has hurt patient care (including 13 percent who said it has "considerably diminished" the quality of patient care), compared with 65 percent of their colleagues practicing in rural hospitals (including 8 percent who said it has "considerably diminished" the quality of patient care). Table 1 compares physicians' responses regarding the effects of PPS on the quality of patient care based on demographic characteristics.

Hospital Services

Internists were asked specific questions about the positive and negative effects of DRGs on both hospital administration and patient care. Responses indicate that DRGs have had mixed results; although PPS has had the desired effect of containing hospital costs, it also had reduced hospital services and lowered the quality of patient care.

Survey data clearly suggest that PPS has helped contain hospital costs. Eighty-seven percent of the respondents indicated that DRGs had increased hospital and medical staff costs awareness for care provided to Medicare patients. Physicians' cost consciousness resulted in fewer unnecessary hospital admissions, according to 50 percent of the respondents, as well as less use of unnecessary tests and procedures, according to nearly a third (27 percent) of the respondents. Many of these services, however, were shifted from the hospital setting (paid for by Medicare Part A) to the outpatient setting (Part B). One internist's comment was typical of others received when he said, **"I have greatly increased services offered by our clinic that previously were [performed] at hospitals."** Aside from these benefits to the Medicare program, 71 percent of internists indicated that PPS also has increased hospital and medical staff awareness of non-Medicare patients' health care costs.

The survey data also indicate that PPS generally has not resulted in hospitals restricting the privileges of physicians perceived as being "too costly." Although it was initially feared that PPS would encourage hospitals to limit physician privileges of those who, on the average, were more costly than other physicians, regardless of the quality of care provided or the severity of their patients' illnesses, only 11 percent of the survey respondents indicated this has occurred.

Table 1

OVERALL EFFECTS OF PPS ON THE QUALITY OF PATIENT CARE

	Considerably/ Somewhat Improved	No Change	Somewhat Diminished	Considerably Diminished
All Members	4%	31%	53%	12%
Urban	4	30	53	13
Rural	5	30	57	8

Under 150 beds in hospital	5	29	56	10
150-299 beds in hospital	4	29	52	15
300-500 beds in hospital	2	32	52	14
Over 500 beds in hospital	7	32	53	8
Northeast	2	37	48	13
South	5	28	53	14
Midwest	2	30	57	11
West	5	30	56	10
General Internal Medicine	3	33	52	12
Subspecialists	5	29	53	13
MDs with 5 or less hospitalized patients per month	6	35	50	11
MDs with 6-10 hospitalized patients per month	3	31	50	16
MDs with more than 10 hospitalized patients per month	4	28	58	10

While eighty-seven percent indicated that PPS had made practitioners and providers more aware of health care costs, a nearly identical percentage (86 percent) did not believe that prospective payment had improved relations between hospitals and their medical staffs. In fact, rather than encourage cost efficiency through greater cooperation among the staffs, 53 percent of the internists reported that under PPS hospitals have pressured them to alter normal and appropriate patterns of care in order to contain costs. For instance, one physician reported that his **"hospital places daily 'tabs' in front of the progress notes to remind you of the [Medicare] patient's bill."** Physicians also reported pressure from their hospital utilization review committee to discharge patients. Another physician commented that **"DRGs have significantly reduced hospital reimbursement, thus creating tension in hospital/physician relations."**

Table 2 shows internists' responses to a variety of positive effects of DRGs.

Table 2

WHETHER DRGs HAVE HAD THE FOLLOWING POSITIVE EFFECTS

	Yes	No	Not Sure
Increased hospital and medical staff awareness of the cost for care provided to Medicare patients	87%	9%	4%
Increased hospital and medical staff awareness of the cost for care provided to non-Medicare patients	71	20	9
Reduced unnecessary hospital admissions	50	30	20
Caused less use of unnecessary tests and procedures	27	55	18

Resulted in efforts by hospitals to restrict the privileges of physicians who are "too costly"	11	68	21
Improved relations between the hospital and medical staff	5	86	9

Although PPS has helped control hospital costs, it has had serious negative effects. The most frequently cited problem by internists (54 percent) has been short staffing of hospital nurses. Since there currently is a national shortage of nurses, it is difficult to know whether the inadequate staffing of nurses is directly attributable to the prospective payment system or to the overall nursing shortage. Nevertheless, only 18 percent of the respondents were certain that short staffing of nurses was not caused by PPS. Similarly, one out of three practitioners felt that PPS has caused short staffing of laboratory personnel. One representative comment by a physician was that the **"cost squeeze on hospitals has caused marked reductions in nurses and the closure of our hospital's observation unit."** Another internist observed that there have been **"delays in tests and in patient instructions due to inadequate staff."**

The survey also indicates that 21 percent of the respondents felt that in some instances prospective payment has discouraged their hospitals from purchasing technologically advanced equipment that has the potential for improving patient care. Less frequently reported problems with DRGs were (1) decisions by hospitals not to treat certain illnesses because of costs related to those health problems (18 percent) and (2) pressure on physicians to admit patients with certain illnesses to other hospitals (13 percent) to minimize their costs.

Table 3 contains internists' responses to the potential negative effects of DRGs.

Table 3

WHETHER DRGs HAVE HAD THE FOLLOWING NEGATIVE EFFECTS

	Yes	No	Not Sure
Caused short staffing of hospital nurses	54%	18%	28%
Caused short staffing of hospital lab technicians	31	27	42
Resulted in a decision not to install a technologically advanced piece of equipment that has the potential to improve patient care	21	44	35
Resulted in a hospital decision not to treat certain illnesses	18	62	20
Resulted in hospital putting pressure on physicians to admit patients with certain illnesses elsewhere	13	77	10

In considering the effects of DRGs, special attention needs to be focused on the specialty of oncology. These specialists reported nearly twice as frequently as other physicians that DRGs had resulted in (1) a decision by their hospitals not to install technologically advanced equipment that could improve patient care (39 percent compared to an overall average of 20 percent) and (2) short staffing of lab technicians in hospitals (52 percent compared to an overall average of 31 percent).

A contributing factor to these shortages appears to be poor reimbursement for oncology DRGs. As one oncologist wrote, **"I cannot expect my hospital to treat acute leukemia patients whose hospitalization always costs $20,000 for induction (intensive initial chemotherapy) and the DRG is only $4,000."** Another oncologist concurred: **"Acute leukemia costs far more than the DRG pays (by 3-4 times as much). I refer [acute leukemia patients] elsewhere as smaller hospitals cannot absorb the loss."** Still another oncologist noted that there is **"inadequate reimbursement for patients who require anti-cancer chemotherapy." "Reimbursement for IV during treatment under DRG 410 [chemotherapy] is inadequate for any treatment over two days,"** according to yet another oncologist.

Patient Care

The survey provided strong evidence that, in addition to creating concerns about hospital administration, prospective payment has diminished the quality of patient care. A major concern for internists is the extent to which they feel pressured to alter their behavior to minimize hospital costs. Sixty-three percent of the survey respondents claim they and their colleagues are under pressure to discharge patients earlier than what they consider to be medically appropriate, indicating that patients still are being released "sicker and quicker." One physician commented, **"I have felt pressured to get people out of the hospital and end up readmitting them sooner."** Another internist reported that **"seeing the bill on the record encourages house staff [residents] to discharge [patients] prematurely."**

The data also indicate that part of the problem is that Medicare patients, hospitals and/or physicians do not understand how the Medicare pricing system works. The Health Care Financing Administration (HCFA) has clearly stated to both Medicare providers and beneficiary groups that "the mean lengths-of-stay in the DRG tables are furnished only for purposes of illustration." HCFA has further emphasized that "the physician is the appropriate individual to decide the proper length-of-stay for a particular patient." Nevertheless, 55 percent of the physicians reported instances where patients have been released because their "DRG coverage ran out."

Physicians also experience pressure to delay admitting patients to the hospital until they are sick enough to meet the PRO's admissions criteria. This problem was confirmed by a high number of respondents (55 percent). Further, a smaller but significant number of internists (24 percent) reported instances where either they or their colleagues felt pressure to underutilize medically necessary tests and procedures.

Following are comments of physicians with respect to delayed admissions:

- **"[I] frequently delay admissions, especially chronic obstructive pulmonary disease (COPD) patients, until 'sick enough' to pass the DRG criteria."**
- **"Severe lower respiratory infections [are] treated on an outpatient basis until patient illness has decompensated (deteriorated) to the point felt to justify admission."**
- **"Elderly patients [are] not admitted when ill because admission criteria [are] not passed, yet [the patient] should be hospitalized."**

Internists also reported pressure to "game" the system to increase Medicare reimbursement for the hospital. Fifty-three percent of the respondents indicated pressure to increase short-stay admissions, and 36 percent of the physicians reported pressure to discharge patients when they need additional treatment, especially if it is not related to the patients' principal diagnoses, and then readmit them at a later time to provide additional reimbursement for that procedure or additional care. Thirty-nine percent of the respondents also reported pressure to upgrade the severity of their diagnoses to maximize Medicare reimbursement.

Following are typical physician comments on how they have changed their hospital practices under PPS:

- **"Many patients are now being admitted for 24-hour observation in order to adequately prepare them for tests or to observe afterward."**
- **"[There] is increased use of the emergency room to avoid denial of admissions."**
- **"[I] have listed diagnoses in order of payment and not order of medical**

importance."

- **"If two principal diagnoses are justified by the record, [I] will use the one with the highest DRG."**

Table 4 shows in more detail how PPS has affected patient care.

Table 4

WHETHER MEMBERS HAVE EXPERIENCED PRESSURE TO DO THE FOLLOWING AS A RESULT OF DRGs OR BEEN AWARE OF THESE PROBLEMS OCCURRING

	Yes	No	Not Sure
Discharge patients earlier than medically appropriate	63%	34%	4%
Delay necessary hospitalization to ensure that patient becomes sick enough to meet the PRO criteria	55	40	5
Inform patients they had to leave the hospital because their "DRG coverage ran out"	55	42	3
Increased short-stay admissions	53	39	8
Upgrade the severity of a diagnosis to maximize reimbursement	39	54	7
Discharge patients and then readmit them within the next few days or weeks	36	61	3
Underutilize medically necessary tests and procedures	24	68	8

Oncologists, again, were more concerned over the effects of PPS on patient care than other specialists. Twenty-three percent of oncologists, compared to 12 percent of general internists and 13 percent of other specialists (Table 1), felt that PPS had "considerably diminished" the quality of patient care. One oncologist commented that he **"cannot admit chemotherapy patients no matter how much difficulty they've had with previous treatment."** Another concurred, stating: **"As [an] oncologist, [I] frequently need to treat [individuals] as outpatients in spite of severe vomiting."** A third oncologist reported that to avoid denials he has to **"wait until the patient is dehydrated rather than admit when illness is severe."**

Post-Hospital Care

Survey responses indicate that post-hospital care remains a concern under PPS. Most of the concern, however, is focused on nursing or home health care rather than the discharge planning provided by hospitals. As one physician noted, **"Everyone feels pressure to get people out quicker now; discharge planning is now brought up in the emergency room before admission."** Another physician echoed this comment: **"On every patient there is pressure to dismiss or plan dismissal the minute they are admitted."** These comments are representative of the 84 percent of physician respondents who indicated that discharge planning is adequate for Medicare patients, a sentiment that is shared throughout most ASIM subgroups, as can be seen in Table 5.

Table 5

WHETHER RESPONDENT'S HOSPITAL HAS ADEQUATE DISCHARGE PLANNING FOR MEDICARE PATIENTS NEEDING POST-HOSPITAL CARE

	Yes	No	Not Sure
All Members	84%	11%	5%
Urban	84	11	5
Rural	81	11	8
Northeast	81	15	4
South	81	13	6
Midwest	85	7	8
West	89	7	4
General Internal Medicine	83	11	6
Specialists (total)	85	12	3
Hematology/Oncology	63	32	5

Although the survey indicates that hospitals are largely providing needed discharge planning, prospective payment has generated a need for nursing home or home health care that many communities cannot meet. Fifty-nine percent of the respondents from all ASIM subgroups reported problems with the availability of nursing homes. Frequent member responses to this problem are as follows:

- **"Yes! Yes! Yes! I can't get enough (ICF) beds!"**
- **"Absolutely, the #1 problem!"**
- **"Insufficient nursing home beds in quality homes!"**
- **"A major problem!"**

Even some physicians who did not feel there was a shortage of beds (41 percent) felt there were problems with nursing home care:

- **"Facilities are available but Medicare doesn't always allow coverage."**
- **"[There are] inadequate nursing home beds for patients without personal resources for payment."**

Shortages in nursing home care was, again, a particularly acute problem for oncologists. Seventy-three percent (compared to an overall survey average of 59 percent) do not feel there is adequate or available post-acute care. One oncologist noted that he has **"difficulty discharging dying, terminal patients."** Another oncologist lamented that **"no nursing home in our area will take true skilled care,"** echoing other members' comments.

PEER REVIEW

ASIM asked its members whether they experienced pressure from their physician colleagues, hospitals and/or PROs to alter their normal patient care. Clearly, PROs are the dominant influence on physicians' utilization of hospital services and the quality of patient care. Fully 69 percent of the respondents said they have experienced pressure from their PROs "to alter [their] normal care of patients." Fifty-three percent of the respondents said that hospitals had pressured them to change their care; only 16 percent experienced pressure from their colleagues to do so. Table 6 contains sources of pressure for altering patient care.

Table 6

SOURCES OF PRESSURE TO ALTER NORMAL CARE

	Yes	No	Not Sure
Hospital	53%	43%	5%
Physician colleagues	16	81	3
PRO	69	27	4

Although a significant number of the respondents indicated they felt pressure from hospitals to alter their normal care, the pressure from PROs was perceived as more direct. Sixty-two percent of the respondents have felt pressured by the implicit threat of a PRO denial of their care. A smaller, yet significant proportion of internists (40 percent) reported feeling pressured by the implied threat of a PRO sanction.

Hospital pressure, on the other hand, appears more subtle. Only 8 percent of respondents felt pressured to alter their normal care because of any implied threat of losing their hospital privileges. Even fewer respondents (3 percent) were pressured to alter their care by an explicit threat of losing their hospital privileges. Rather, hospitals pressure physicians by closely monitoring their diagnoses and utilization. As one internist reported, he feels **"tremendous pressure by hospitals to discharge patients early or transfer [them] to a skilled nursing facility (SNF), often making us feel guilty after refusing to transfer or discharge until medically indicated."** Another physician reported that **"hospital people fill out [the] DRG sheet to get maximum payment."** A third internist concurred by stating that he is **"often asked to change [his] diagnosis to [a] 'better payer.' "**

Similarly, peer pressure is not a major factor influencing physician practice patterns. Only 8 percent of the respondents felt threatened by the loss of their physician colleagues' respect, and only 2 percent reported any verbal threat of losing colleagues' referrals. Table 7 contains physician answers regarding types of pressure to alter their patient care.

Table 7

TYPES OF PRESSURE FOR ALTERING PATIENT CARE

	Yes	No	Not Sure
Implied threat of losing hospital privileges	8%	89%	3%
Verbal threat of losing hospital privileges	3	96	1
Implied loss of respect from colleagues	8	89	3
Verbal threat of losing colleagues' referrals	2	96	2
Implied threat of a PRO denial of care	62	35	3
Implied threat of a PRO sanction	40	56	4

Respondents had widespread criticism for the PRO program. Sixty-eight percent of the respondents had what they believed was medically justified care denied by PROs. Added to this frustration was the fact that nearly half (46 percent) of the respondents felt they did not get a proper explanation for the denial of their care. Further, one out of three respondents (33 percent) felt that their appeal of a denial was not handled with proper consideration.

These negative experiences with the PRO program also are reflected in the members' assessment of its effectiveness. Sixty-three percent of the respondents indicated that they did not believe the program is cost effective. Only 9 percent of the internists surveyed felt that the PROs had actually recommended sanctioning a practitioner who provided poor quality or unnecessary care.

Physicians' comments on the peer review program reveal anger over its interference with their practices. Frequently members complained about the "**time involved to rebut denials.**" One internist was frustrated with the "**unprecedented increase in administrative time dealing with DRG forms, denials of care, etc.**" Another physician complained that the PRO reversed its denial of his medically justified care, but only after "**painstaking protests.**" Such experiences led many physicians to conclude, in the words of one internist, that the PROs "**seem to be on Medicare's side — not the doctors' and certainly not the patients'.**" Still others have grown cynical, calling peer review a "**political ploy to initiate paper games and paper wars.**"

CONCLUSION

The ASIM survey results reveals that after four years of prospective payment internists believe that a number of serious problems with patient care persist. Although PPS has raised physicians' cognizance of health care costs, the system also has generated pressure and created negative incentives that seem to decrease the quality of Medicare patients' health care. These problems are evident not only in hospital services provided to patients, but also in their post-hospital care. Ironically, PROs -- the organizations established to monitor the quality and utilization of patient care -- are perceived as the largest obstacle to physicians providing what they believe is appropriate care. Physicians not only feel they must change their practice patterns to meet the PROs' criteria, but many of them also feel threatened by the PROs' authority to sanction them.

The survey also indicates that special attention may need to be focused on the treatment of cancer under Medicare PPS. Oncologists' responses point to inadequate compensation to hospitals for cancer treatment, inadequate hospital access for oncology patients and a general lack of post-hospital care for the terminally ill and others needing long-term care.

These data strongly suggest that Congress and the Administration need to examine more closely the effects of PPS on Medicare patients and implement changes that provide adequate reimbursement for and appropriate flexibility in caring for patients' medical needs. The survey also suggests that studies, such as that mandated by the 1986 Omnibus Budget Reconciliation Act (OBRA) to develop strategies for quality review, are especially important for developing quality assessment of patient care. Further, greater attention needs to be paid to the PRO program to ensure that review organizations are responsive to the medical community's concerns. Finally, given the impact of DRGs on not only inpatient health care but also care provided in ambulatory and nursing home settings, the survey points to the need for a centralized effort on behalf of DHHS (as mandated by OBRA) to assess the quality of patient care under prospective payment.

SURVEY METHODOLOGY

The survey was designed and conducted by Lauer, Lalley and Associates. The questionnaires for this survey were sent to a representative sample of ASIM members on October 15-16, 1987. (Members from Maryland and New Jersey were excluded from the sample because those states have waivers under the Medicare program.) Each questionnaire was accompanied by a letter explaining the purpose of the survey and requesting that members complete and return the questionnaires (Attachment 1). On November 5, 1987, a second mailing was sent to members who had not responded to the first mailing.

The sample for this survey represents an accurate cross section of the ASIM membership. A systematic selection process was used by ASIM to select every *nth* name from the membership files.

A total of 1,766 questionnaires were sent out in the initial mailing. The data in this survey are based on the results of 648 completed questionnaires. The margin of error for a sample of 648 respondents is plus or minus 3.7 percent at the 95 percent confidence level. Smaller subgroups of the sample are subject to larger margins of error ranging up to 10 percent. In addition to the 648 questionnaires used in the analysis, another 25 questionnaires were either received after the data had already been tabulated or returned uncompleted. We received a total of 673 questionnaires, a response rate of 38 percent.

STATEMENT

OF

MICHAEL D. BROMBERG
FEDERATION OF AMERICAN HEALTH SYSTEMS

The Federation of American Health Systems is the national association of investor-owned hospitals and health care systems representing over 1,400 hospitals with over 174,000 beds. Our member management companies also manage under contract more than 350 hospitals owned by others.

Medicare Hospital Prospective Payment System

We view the major problem with the current Medicare prospective payment system for hospitals as one of budget priorities. The deficit reduction laws have resulted in disproportionate cuts to Medicare whose share of reductions has been almost twice its share of outlays. Hospitals in particular have been adversely affected.

The Part A Trust Fund has not accounted for one penny of the federal deficit. Actually, the deficit would be much higher if the trust funds were not contributing their surpluses to the deficit calculations. Notwithstanding that fact, Medicare has absorbed nearly 25 percent of all non-defense cuts and 16 percent of total budget cuts for the past seven years. The proportion of those cuts is far out of line with any sense of equitable deficit reduction because Medicare outlays represent only 7.5 percent of total federal outlays.

When prospective payment was enacted in 1983, our association strongly supported and actively worked for passage of the legislation. In fact, we first urged Congress to enact some type of prospective payment system as early as 1966 because we believed that positive incentives could improve efficiency. The DRG system has accomplished that objective. Expenditures have been cut saving the Medicare program billions of taxpayer dollars and the Medicare Hospital Insurance Trust Fund has a longer life expectancy.

The hospital industry supported a bill in 1983 which provided for fixed DRG prices. These prices were to be increased annually by an agreed upon market basket index reflecting the annual increases in the cost of goods and services purchased by hospitals.

For three years in a row the Administration and Congress have amended that law to cut by more than 50 percent the rate of increase promised to hospitals. The rationale or excuse for cuts in the DRG update in fiscal years 1985, 1986, and 1987 was the serious federal budget deficit. Hospitals responded to that argument by agreeing to participate in any fair, across-the-board budget deficit reduction plan. Hospitals pointed out though, that defense spending was rising while Medicare was being cut at a rate nearly double its share of federal outlays.

Hospital Profitability

According to a recent study by Consolidated Consulting Group, new HCFA data indicate that Medicare profits are much lower than previously estimated and are declining rapidly. Original HCFA data from the first year of the prospective payment system (PPS-1, 1983 - 1984) projected fiscal 1988 profits at 10.0 percent. Estimates derived from the second year data (PPS-2, 1984-1985) put FY 1988 profits at 5.0 percent. Projections based on PPS-3 data covering hospital fiscal years for 1985-86 show that the average hospital will lose $1-3 on every $100 of Medicare inpatient revenues (See Exhibit One). Furthermore, about 55 percent of hospitals will lose money (have a negative margin) on their Medicare business. Simply put, even the government's own data now show that most hospitals face a loss situation by the end of 1988.

The costs of the goods and services hospitals buy will have increased almost 32 percent from 1983 to 1989. By contrast, the Medicare update factor will have increased about 13 percent (See Exhibit Two). If price increases lag almost 19 percentage points behind increases in the cost of what hospitals must buy to provide care, there is simply no way that most hospitals can generate the modestly positive margin they need to provide the quality of care that Medicare beneficiaries should have.

We urge the Committee to maintain the rate of increase at the average rate of market basket minus 2 percent enacted last year for fiscal 1989 and to return to a full market basket increase for fiscal years 1990 and beyond. Failing some method for providing adequate updates, we would urge Congress to simply admit that it cannot finance its past promises to the elderly and either raise taxes, increase copayments, establish a means test or consider authorizing hospitals to charge additional amounts to those beneficiaries who are able to pay, in order for hospitals to maintain financial solvency.

If nothing is done to change the trend toward inadequate payment updates, hospitals will be forced to reassess their support for the program. Patients will realize and react to the simple fact that they are the ones who suffer the consequences of Congress authorizing inadequate payment for services.

Factors Contributing to Falling Medicare Operating Margins

The notion expressed by some that hospital margins have fallen because costs have not been contained is not supported either by the facts or the incentives of the Medicare prospective payment system. In the early years of the prospective payment system incentives worked very well and costs were reduced. The first year of the new prospective payment system yielded dramatic cost cutting by hospitals and savings to the Medicare program. Medicare Part A expenditures for 1984 were 6 percent or $2.2 billion less than projected. Reductions in the growth of hospitals' full time equivalent (FTE) employees, the first reduction since World War II, shorter lengths of stay and fewer inpatient admissions resulted in sizeable savings to the Medicare program and improved operating margins for hospitals. However, many of those reductions, particularly those related to jobs and wages, the largest budget item for hospitals (60%), are a one time phenomenon. They cannot be duplicated every year to produce the great savings achieved during the early phases of the prospective payment system without jeopardizing quality of care.

It is worth noting, from a cost viewpoint, that hospital spending as a percentage of Gross National Product (GNP) has not increased for several years. It has remained at 4 percent of GNP while total health expenditures have risen during that same period from 9 percent to 11 percent of GNP. On a per capita basis, adjusted for inflation, Medicare payments to hospitals actually decreased by 2.5 percent from 1984 to 1987 while Medicare expenditures for non-hospital services increased 27 percent.

The Medicare prospective payment system has brought about a revolution in the health care system. The change from cost reimbursement came at a time when private insurers and employers also were flexing their buying power and pressuring hospitals to cut costs in order to reduce increases in health insurance premiums. These changes in the health care market place have had some positive, very positive, effects. However, we need to examine more closely the long term effects of some of these changes.

Several major factors are contributing to the increase in hospital expenses. Inpatient costs in 1987 have increased by 8.1 percent. Of that, 6.3 percent went to goods and services that hospitals buy (excluding capital and malpractice) and 1.8 percent went to the volume of services.

The costs of labor and other items hospitals must buy to treat the sick have been rising faster than the Consumer Price Index. While the Consumer Price Index rose 4.3 percent in 1987, prices hospitals pay increased by 6.3 percent (AHA Market Basket, September 1987 versus September 1986).

There has been a dramatic shift in the site of treatment for many Medicare beneficiaries. As modern technology and improved peer review of the medical necessity for inpatient care permit and encourage a shift to outpatient treatment, the average inpatient is a very different patient. Many procedures once performed in the acute care hospital setting are now done on an outpatient basis. Consequently, the remaining Medicare patients in acute care hospitals are sicker, and require a higher and more costly level of care.

Hospitals must provide skilled staff to treat the increasingly older and more severly ill Medicare population, at a time when we are experiencing a severe nursing shortage. Hospitals must increase wages to maintain highly competent staff. Nursing costs, a main labor cost component, are estimated to rise this year by 8 percent or more due to a rising demand for nurses in non-hospital settings, such as free standing ambulatory surgical centers and the need to keep pace with salaries in other professions, such as teaching. Hospitals must also compete with those that can provide more desirable working conditions, not the frequent night and weekend shift work required in the hospital setting.

The amount of nursing resources and skill mix of other employees required per admission is higher than ever before and is not reflected in the hospital market basket. The HCFA market basket is calculated by analyzing wages in nine service industries, eight of which are outside the health sector. Had HCFA used only hospital workers' salaries, the market basket would have been 1.4 percentage points higher in fiscal year 1988. This difference represents a shortfall of about $500 million in Medicare payments to hospitals.

Another factor leading to higher hospital expenses is the greater use of expensive new technology and procedures which in many instances result in a better outcome with less risk to the patient.
For example:

- Magnetic Resonance Imaging
- Opthalmological Laser Surgery
- Organ Transplantation
- Positron Emission Tomography
- t-PA
- Cochlear Implants
- Implantable Defibrillators

Contractual allowances (discounts in the charges for health care services) have been rising rapidly since 1985. Private insurers and employers now negotiate with providers for discounted rates. Also, private payers will no longer bear the cost of caring for America's uninsured population. Consequently, hospital losses incurred by charity care and bad debt have been rising steadily. The amount of uncompensated care provided by hospitals has grown from $4.7 billion in 1983 to almost $7 billion in 1986, representing 5 percent of their gross patient revenues.

Conclusion

The Federation of American Health Systems supported the enactment of a prospective payment system as a way to provide hospitals the correct incentives for providing quality care at an efficient price. Most significantly, the response of hospitals to the new incentives under PPS has resulted in enormous savings to the Medicare program, and prolonged the life of the Medicare Trust Fund well beyond the next decade.

Hospitals have contributed more than their fair share toward deficit reduction. Hospital operating margins under Medicare are declining rapidly -- to the point where more than 50 percent of the nation's community hospitals are expected to lose money in 1988 from the costs of treating Medicare patients.

The increases in discounts to private payers and in the costs of uncompensated care is evidence that it has become more difficult to shift costs to the private sector. This inability to have private payers absorb the shortfall produced by continuing underpayments from the Medicare program and the large, growing indigent care population will exacerbate the already deteriorating operating margins of hospitals.

We urge the Subcommittee to refrain from amending the Medicare PPS system during 1988 in order to allow hospitals to digest the hundreds of amendments passed during the past several years. Further cuts in PPS payments would adversely impact quality and access to care for millions of Americans, the elderly and non elderly alike.

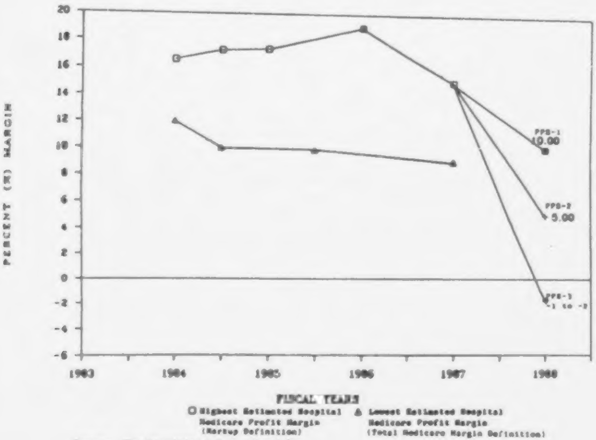
We urge the Subcommittee to study major restructuring of the Medicare program so that action may be taken next year to assure access by all Americans to quality care. Specifically our nation must reach a public policy agreement on protection for 37 million uninsured and adequate financing of care for beneficiaries of existing programs.

If Congress concludes that the budget deficit does not allow government to meet these needs, then other mechanisms must be utilized. If the surplus in the Medicare Part A Trust Fund is used to reduce the federal deficit, even though the Medicare hospital benefit has not contributed one cent to the national debt, then one way to provide fair and adequate payment for quality hospital care is to ask those beneficiaries who are able to pay more for their care to do so.

This can be done by taxing the value of the benefits, a progressive, means testing approach. Another way to restructure the program is to broaden the private insurance options available to beneficiaries. We also urge a demonstration program to provide all new beneficiaries -- those reaching age 65 next year -- the option to keep whatever private insurance they have with Medicare paying all or part of the premium based on the same standards used to pay Medicare HMO's or MIG's.

We urge the Subcommittee to end the annual charade of using budget reduction targets as a justification for inadequate payment. Unless admit that inadequate funding leads to inadequate care, we will e the system deteriorate.

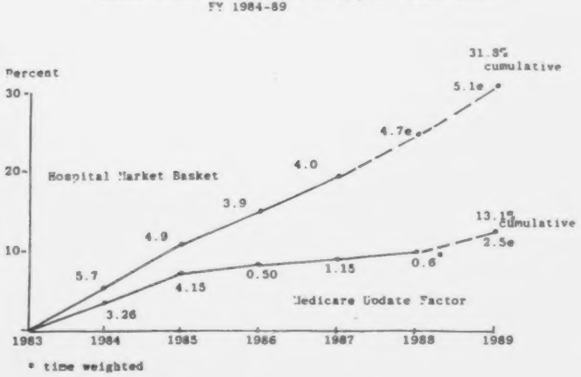
EXHIBIT ONE: EXTREMES OF HOSPITAL MEDICARE PROFIT ESTIMATES, FY 1984 - FY 1988



Source: The Consolidated Consulting Group

EXHIBIT TWO

Update Factor Vs. Increase in Hospital Input Costs
FY 1984-89



* time weighted

Source: FAHS, based on HCFA and ProPac Reports

STATEMENT OF SOPHIA HASEN
CANTON, OHIO

My husband, Hamit I. Hasen, was murdered! What's more, I am being told it was legal. No one will go to jail for it. However, the purpose of this report is not to seek punishment - it is a prayer for change in today's Medicare guidelines.

My name is Sophia Hasen, and I live at 1538 Monument Road, N.W., Canton, Ohio 44703. I am submitting this testimony as an American citizen. Officially I speak for no one else but I am convinced that others would echo what I say if they had access to the information and experiences I have had.

The weapons which killed my husband were not guns or knives, or other such objects. The weapons were the infamous DRG's (Diagnostic Related Groups) and especially the PPS (Prospective Payment System), which, I am told, were devised by some brainstorming intellectuals at Yale, were borrowed by Medicare and implemented into Medicare as today's guidelines.

It is claimed this was done for economic reasons, and this is probably true. However, these two monstrosities have backfired and developed into a legal license condoning the killing of Medicare beneficiaries at random.

If you think this is a strong, bold statement, you are right! But in my opinion it is the truth and I pray that it will jar you into full realization that numerous tragedies, such as death and cripplings, are occurring across America which are caused mainly by the PPS.

It is easier to condemn another's statements and personal views than it is to face the facts one is being told, but this matter should clearly be faced and changed for the better. If you will seek you will find there is a proliferation of articles, reports, studies, TV programs, complaints, personal stories, etc., to support my statements one hundred percent (see attached articles).

The most important and positive proof that Medicare beneficiaries are being "dumped" out of hospitals prematurely, while in unstable condition, only to die or remain crippled, is contained in an Associated Press report about an investigation by Peer Review Systems, that is headlined, "Review: 22,000 Lives Lost Yearly with Poor Medicare Treatment." My husband was one of the group of 22,000 who died. I believe this report has credibility because it was done from the records of the PRO.

I do not feel that I should quote anything from the report, since it had been released many months ago and all Medicare personnel, especially Medicare administrators, must have read it, or should have read it. However, I don't mean read it and forget it. Read it and be serious about its findings.

My husband, Hamit, died needlessly because he was "dumped" out of the hospital while having severe chest pains. He told the doctor of the pain he was suffering but she ignored this. You see, it was his 16th day in the hospital with a heart problem and the prepaid amount from Medicare had been utilized, so he was discharged and sent home by ambulance, even though it was only a five-minute drive from the hospital to our home. He died four days later.

My husband's needless death is not one isolated tragedy. It is one of the many thousands of such tragedies and it is growing! That is how I see it from the research I have done, and that is how Medicare administrators would see it, too, of they would simply remove their dollar-sign glasses. I am not ignorant of the fact that money is a necessity for every individual just as it is on up to the federal government. And, I can also understand the very evident pride shown by Medicare administrators as they make assurances that "Medicare is now solvent." But what I cannot accept is the terrible price Medicare beneficiaries are paying for that solvency!

I suspect that at this point you may be wanting to tell me about the Peer Review Systems (PRS). Please don't even mention the PRS as I have already dealt with them. They are, in my opinion, totally useless to Medicare patients. In my husband's case both the hospital and doctors committed gross and flagrant violations in the care of my husband, when they "dumped" him out of the hospital while he was suffering severe chest pains due to his heart problem. I repeat, he was in imminent danger at the time of his discharge from the hospital.

After my husband's death I requested the PRS to conduct a retrospective review of my husband's medical care, and the gist of their conclusions was that "he would have died anyway." However, we'll never know for certain, will we? He was not given that little extra time and care in the hospital that might have saved his life.

My next step was to ask my attorney to conduct an investigation into my husband's death and the results (conclusions) from that investigation are outlined as follows (I am quoting a letter from my attorney to my husband's doctor and the president of the hospital at which he was a patient):

> I have been contacted by the widow of your former patient, Hamit Hasen, in order to prosecute a medical malpractice case against you for Mr. Hasen's wrongful death. As part of my investigation, an independent, board certified cardiologist reviewed all of Mr. Hasen's medical records. His conclusion is that Mr. Hasen did not receive acceptable medical care in the following areas:
>
> 1. He was admitted for a heart attack, but was only monitored intermittently with an EKG. He had no EKGs between June 13, 1986, and June 25, 1986.
>
> 2. His cardiac enzymes were significantly elevated on June 11, 1986, indicating that he sustained an additional heart attack in the hospital. Absolutely no one even recognized the enzyme elevation or followed up with additional enzyme testing!
>
> 3. On June 25, 1986, Mr. Hasen began to complain of chest pain. The EKG was not read properly, and no additional testing of any type was ordered. Instead, even though he continued to complain, he was discharged on June 27, 1986, after a cursory examination by a nurse.
>
> Mrs. Hasen initiated a peer review process. Her husband's case was summarily reviewed by a Dr. P, whose specialty is unknown, and another unnamed internist, but not by a cardiologist.
>
> Dr. P indicates that Mr. Hasen's death was imminent on discharge. This may be true. However, no one, either physician or nurse, ever bothered to tell Mr. or Mrs. Hasen that Hamit was coming home to die, that medicine offered him no hope, and that his days were numbered. Whatever opportunity Mr. Hasen had to survive was reduced to nil by sending him home, particularly when no one communicated the true nature of his condition to him or his wife. The Hasens believed he was discharged because he was "better."
>
> Mrs. Hasen believes that her husband was discharged because of the

operation of the prospective payment system of Medicare, that his covered time had expired, and that the hospital put pressure on the treating physician to discharge Mr. Hasen. To suggest that a physician has sole discretion over a discharge so oversimplifies the situation that it is an insult to Mrs. Hasen's intelligence. Certainly, the Utilization Review Committee was "on the ball"; the stamps show up regularly in the records.

Further, Mrs. Hasen's beliefs gain credence given that it was a medical secret until after Hamit's death and her inquiry, that his discharge was to allow him to die where "he was more comfortable in familiar surroundings" as Dr. P suggests.

Based upon the difficulty of proving how long Mr. Hasen would have survived if he had remained at Timken Mercy, particularly considering the sub-standard care he received earlier, I will not be bringing an action for Mr. Hasen's death. However, his care, or lack of it, and the cavalier treatment of Mrs. Hasen are unforgiveable. If Mr. Hasen were discharged to die, someone should have informed him and his family. If he were discharged because of hospital politics and economics, then you too should be working to change the system as Mrs. Hasen now works.

Sincerely,

Attorney A. William Zavarello

It was after I received the report of conclusions reached by the independent, board certified cardiologist who investigated my husband's death that I realized those little quirks of doubt about my husband's care were really suspicions, which the cardiologist's findings showed to be true. But at the time both my husband and I were naive in believing Dr. H was a good, caring doctor. In addition, it was a difficult time for me. I was devastated by fear for my husband's life as I waited in an emergency ante-room while he was being given emergency treatment. I felt as though I had spent forever in that little room - waiting, praying, waiting, praying and trying hard not to show I had been crying.

Finally I was told my husband was being taken "upstairs" to the Intensive Care Unit and I could follow, but when we came within sight of the ICU wing I was motioned to another waiting room where I spent the next 72 hours. I was permitted to see my husband for 10 minutes twice a day.

For the next three days I tried to talk to my husband's doctor, but she was either busy, or out, or unavailable, so I watched the hallways in order to catch her coming or going. So it was not until three days after my husband was admitted that Dr. H told me my husband had had a heart attack, but her reply to my many other anxious questions was a simple, "We have to do more testing."

Her answer to my question about putting my husband on a life support system was that she would not recommend it because it would be very painful and miserably uncomfortable and it would be cruel to put him through such an ordeal.

On or about June 15, 1986, I learned that Dr. H went away for a week and Dr. S, her associate, would be caring for my husband. Well, the care he got from Dr. S for that whole week was a one-time wave from the doorway. He never once came into the room to examine my husband. Medical records indicate Dr. S stopped at the nurses' station once during the whole week

Dr. H was away, which was on June 18, 1986. Yet Medicare was billed for daily visits.

Later on, that same day, June 18, 1986, I finally spotted Dr. S walking along the hospital corridor and I almost ran to catch up to him, feeling relieved that my three-day vigil finally paid off. In answer to my questions about my husband's condition, Dr. S replied, "Oh, he's OK," and he kept right on going, leaving me totally frustrated.

Dr. H returned on or about June 22, 1986, and as I sat in the waiting room keeping vigilance, I saw Dr. H go by so I caught up and began asking questions. I wanted to know how serious was my husband's condition. Or, was it not serious anymore since he had been taken off the heart monitor several days before? Dr. H replied that we may lose him yet. I considered this a non-definitive answer, and I asked for a detailed explanation to help me better understand the true degree of the severity of Hamit's illness, but the doctor was in a hurry as usual, and left before I could say anymore.

On June 26, 1986, Hamit told me he was being discharged from the hospital the next day, which was the 16th day of his hospitilization, and it was also the day Medicare coverage ended. I guess I could not hide my disbelief because Hamit was still so pale and weak! Later, I called the doctor's office, determined to find out just why Hamit was being discharged so soon. However, the secretary said Dr. H was busy, but she (the secretary) would take a message if I would tell her what I was calling about. I replied that I wanted to know why Hamit was being discharged so soon while he still seemed so very ill, especially in view of the fact that when he had his first heart attack 20 years before, he was kept in the hospital for 54 days, until the heart muscle was well on its way in the process of healing. I also asked why something more wasn't being done for him, and she replied with a question of her own, saying, "Well, what else can be done?" Dr. H did not return my call.

When I walked into Hamit's hospital room the next day (June 27, 1986), Dr. H was there, and we were informed (by Dr. H) that Hamit's hospital release was signed but he had to be taken home by ambulance. Why? The doctor knew it was only a five-minute drive from the hospital to our home.

Dr. H gave me a couple prescriptions for Hamit's medication (same as what he had been taking for 20 years). Outside of telling Hamit to stay on one floor, there were no other instructions. We were not given a follow-up care plan, or a discharge plan, and there was no discussion regarding physical or possible emotional needs. Then as Dr. H was leaving the room we were reminded that a visiting nurse would be coming in twice a week to check on Hamit, but Dr. H still did not tell me just what was the status of Hamit's health condition. I guess I was naive in believing (at the time) that a doctor would discharge a patient from the hospital only because the patient was well on the way to recovery and not because Medicare coverage ended.

On Monday, June 30, 1986, a visiting nurse checked Hamit's blood pressure, heart, etc. I asked how he was doing and she replied that he was doing as well as can be expected, but it would be best do ask his doctor about that.

On Tuesday morning, July 1, 1986, Hamit shaved, showered, and then had a breakfast of cereal, milk and fruit in the bedroom. When he had finished breakfast I took the dishes and tray to the kitchen, rinsed and dried them, and put them away (total time being about three or four minutes). Then I returned to the bedroom to find Hamit lying on the floor. He was unconscious. I called the paramedics immediately and they arrived within five minutes and started CPR, but after some time they took him back to the Timken Mercy Medical Center where he was pronounced dead.

I know now that Hamit died needlessly for the following reasons:

1. The Infamous DRG's and PPS

Under DRG's, Medicare patients are herded into groups according to "where it hurts" without regard for the vast differences among the patients sharing identical diagnoses. The use of DRG's and PPS as Medicare guidelines is a disgrace to our country. Medicare beneficiaries are given lip service about human rights and social justice, yet the fact is that Medicare beneficiaries have been discriminately singled out and denied these rights in the area of health care. My husband died because he was not allowed a few more days of hospital care which he needed. Under DRG's, Medicare patients are told to get well within a certain time or else, too bad.

A rose is a rose is a rose, may be an oft-repeated expression, but it cannot be applied when it comes to health care. "A heart attack is not a heart attack is not a heart attack," said Dr. David Utlack in a speech to the North Canton Rotary Club on February 4, 1988 (Source: Canton Repository newspaper article). There cannot be a rigid standardization of heart attacks. Dr. Utlack explains that the most profitable patient to the hospital is the patient whose diagnosis brings in a high payment from Medicare and the patient dies in one day, because the hospital is not required to return the money. Dr. Utlack said that applying price controls to the health care industry is the "... most anti-intellectual approach to medicine as we have ever seen...Medicine is not conducive to assembly line production. Death and disease deserve no time cards."

2. The Federal Medicare Program

"Government intervention in health care has thrown roadblocks into the practice of medicine," Dr. Angelo J. Demis told members attending the Visiting Nurse Society of Central Stark County's annual meeting at the Canton Garden Center on September 30, 1987. (Source: Canton Repository newspaper article) For example, Demis continued, the DRG system pays for up to seven days of hospitilization for an acute leukemia patient. However, the average hospital stay is actually four to six weeks - therapy alone takes a week, followed by a period of extreme illness accompanied by danger of infection that requires hospitilization. "Patients with acute leukemia are not getting the kind of care they used to get," said Demis, who is director of the division of medical oncology and hematology at Alliance Community Hospital.

3. The Hospital Administrators

Hospital administrators keep a watchful eye out for the day Medicare coverage ends, that is, when the amount Medicare pays for a certain illness has been utilized. They then pressure doctors to discharge patients regardless of that patient's condition. They did this to my husband, causing his death four days later. All that mattered to them were finances, but it did not bother them that my husband was having severe chest pains at the time of his discharge from the hospital.

4. The Doctors

Sadly, there are doctors who discharge Medicare patients while they are not yet stable, seriously jeopardizing their health and their lives, because they fear loss of hospital privileges. Of all the many doctors I have interviewed, only two said they pay no attention to pressure from hospital administrators. They discharge patients according to their degree of healing. How any doctor can face his/her conscience who discharges a patient, yet notes on his chart, "Prognosis: Poor" is beyond my understanding. Even the Humane Society does better than that for its animals.

5. The PRS and/or PRO

The Peer Review Systems and the Peer Review Organization have never been publicly divulged to Medicare beneficiaries. How does a patient know of their existence? Where does one find their phone numbers? Or their addresses? Why wasn't this information given to Medicare beneficiaries? Why wasn't the information sent out along with Medicare notices or checks?

In addition, I have the following questions: How many American laymen have knowledge and ability to make informed decisions about needed medical care? How many American laymen have the knowledge and ability to evaluate the quality of medical care and services? How many American laymen know enough about a patient's illness and its treatment in order to make informed decisions? My answer to these questions is none! So, how then is the patient or his family to know when to call the Peer Review System, if they can even find the telephone number?

After my husband's needless death I found the PRS number in a magazine. I told them how my husband was discharged while still critically ill, so someone called his doctor and took her word for it, then told me he would have died anyway.

Jane M. Orient, M.D., in a newspaper article entitled "Efficiency Makes All Patients into Losers" (Source: Free Press, Canton, Ohio, August 23, 1987, Page A-5), says: "Paying for what you get, in the hospital at least, has become outmoded. Medicare now pays the hospital for what you have (your diagnosis) and you get whatever treatment the hospital offers." This is called efficiency. Dr. Orient goes on to describe a situation involving a patient who had both an inflamed gall bladder and a skin cancer on his face. The hospital refused to allow both problems to be addressed in one hospital visit:

> "If the skin cancer had been removed during the gall bladder operation, the hospital wouldn't have been paid extra operating room time, or the sutures, or the biopsy. Therefore, they scheduled the patient to come back to out-patient surgery at a later time for his skin cancer. The hospital was rewarded for its efficiency by being paid for two separate procedures, instead of just one.
>
> DRG's are helping hospitals and the federal government eliminate the bother of dealing with patients as individuals. When admitted to a hospital, patients become members of one of the 467 groups. Some of them are "winners" and others "losers." The next step may be capitation: payment by the head, with each patient being treated as a member of an undifferentiated mass.
>
> In that event, all of us will be losers."

On or about August 15, 1987, Dr. Robert Arnot was interviewed on the CBS Morning Show regarding the abuse of early and/or premature discharge of Medicare patients from hospitals because of present-day Medicare guidelines which have put a price tag on diseases and created an adverse effect on the medical care of Medicare beneficiaries.

Dr. Arnot stated, "Patients are being discharged from hospitals before they should be," and added that there are numerous horror stories about Medicare patients being pushed out of hospitals too early, only to die within a few hours or a few days, as did my husband.

Dr. Arnot cited a particular study on hip-fracture patients as an example. He said that in the old days (before DRG's and the PPS) hip-fracture patients stayed in the hospital for 16 days - now it is 10 days. In the old days they used to get twice as much intensive, individual, physical therapy. Now when they're discharged, they can't get out under their own steam, so almost triple the number end up in nursing homes and most of them end up staying in the nursing home for six months. This is a crisis because the government is trying to save money and yet it is hurting the patient. In addition, there are those who die needlessly and those who become totally (permanently) disabled who stay in the nursing home until they finally leave in a hearse.

What a terrible price to pay in human suffering to keep Medicare solvent!

Dr. Arnot asks, "Why is it - are these patients leaving hospitals so early and then not doing so well? And the answer is, of course - they haven't had enough physical therapy in the hospital to be able to get out under their own steam."

Nursing home personnel claim that as a result of pushing Medicare patients out of hospitals too early they come into the nursing homes much sicker than they've ever seen them before. Dr. Arnot goes on to say, "They come out of the hospital into the nursing home. They already have coronary artery disease, they have arthritis, and in the hospital they may have picked up a urinary tract infection or pneumonia, and so in the nursing home what happens is they're unable to do the physical therapy because they're so sick. The nursing homes are simply not equipped to provide acute, intensive care like a hospital and even when they're ready for physical therapy, unfortunately they get it a couple times a week and they get it in a group as opposed to the real intensive kind of physical therapy."

The typical nursing home cannot and does not give the acute care that a hospital can.

A documentary titled "Who Lives - Who Dies" was broadcast over PBS on January 5, 1988, narrated by James Earl Jones.

I will not go into detail on this documentary in the interest of saving space, but here is a brief summary: Unequal access to medical care in America shows very clearly that America is a country with two standards of medical care, one for the people who can pay and one for the poor.

I was admitted to a hospital in May of 1987 due to a fairly well-advanced case of phlebitis. On the fifth day of my hospital stay my doctor told me I would be discharged from the hospital the next day. I could not believe he was serious, for he had just examined my legs and ankles and he could see there was very little improvement. The swelling and discoloration were plainly visible, and I explained that I still had pain in both my legs, and I voiced my objections about leaving the hospital so soon. Then he said he could send me to a nursing home, but I could not stay in the hospital any longer. However, since I did not feel that I was a nursing home candidate, I asked if I could stay a couple days more at my own expense, but the doctor said, "The hospital can't bill you." Thus I was forced to leave and go home on the sixth day with swollen, painful legs.

Before leaving the hospital I was given a prescription for Heparin and syringes and directed to give myself injections of Heparin twice daily. But when my son went to the pharmacy to get my prescription filled, the pharmacist seemed surprised. He told my son that the drug store did not carry Heparin because it should be given in a hospital where blood work can be done every couple days.

My son tried to get my prescription filled in nearly a dozen pharmacies until he found Heparin and syringes in an establishment which caters to nursing homes, and I gave myself daily injections of Heparin for thirty days.

My legs are still very hard and swollen and the pain is constant. The discoloration is not fading, either, and on my last office visit the doctor informed me that the phlebitis in my legs is a "life-threatening condition."

Thirty years before when I had phlebitis I was kept in the hospital for 18 days, until my legs were completely healed, but with the present case of phlebitis I was forced out of the hospital before I could even begin to heal. Is it any wonder my condition is life-threatening?

An acquaintance of mine, Mr. C. Fred Hoch Jr., informed me of a similar problem his father encountered. His father, Charles F. Hoch, was admitted to the hospital with a heart attack on Feb. 6, 1984, and had another heart attack in the hospital on Feb. 8, 1984. His condition had deteriorated to the point where he was given last rites on Feb. 20. However, medical help was continued and he began to improve. However, the next day, Feb. 21, he was informed that he would be taken to a nursing home the next day, which was the 16th day from the day he was admitted to the hospital. Mr. Hoch's father was extremely upset by this news. He had a relapse while being transported by ambulance to the nursing home, and he died four days later. Fred Hoch believes, as do I, that his death was caused mainly because of inhumane Medicare policy, especially DRG's and PPS.

I am certain you have heard and read all I have said here many, many times - from hospital administrators' financial point of view, from doctors, from newspapers and magazines, from TV documentaries and programs, from families of Medicare patients, from the patients themselves, etc., yet Medicare cuts continue. Who else should you hear from in order to be convinced that the use of DRG's and PPS in the Medicare program is Wrong! Wrong! Wrong!

It is time now to scrap (eliminate) the DRG's and PPS and start all over. Surely a lesson has been learned by all - a lesson taught by the thousands of needless deaths of Medicare patients who were, and still are, discharged from hospitals prematurely only to die shortly thereafter as my husband did, plus those who were, and still are, dumped into nursing homes and become totally disabled because nursing homes are not set up to give acute care. They wait, hope, and pray, but you and I know that for the permanently disabled the only way out is by hearse.

Human misery has overpowered human rights and social justice where Medicare is concerned. Certainly there must be a better way, especially for those patients with such acute illnesses whose lives hang on a very thin thread ready to snap just by moving the patient to another area or place. When a Medicare patient is told that he/she will be "dumped" into a nursing home, it is a traumatic shock, and this, in addition to the patient's illness, results in death, either sudden or within a few hours or a few days.

No, I am not a professional in the medical community. All that I have said here is what I have learned from experience, thorough research and studies verifying my stated facts. I have devoted all of my time for over a year to interviews with professionals in the medical community, with Medicare patients and their families and wherever else I could get verifiable information. Neither am I a famous person. I am an average American citizen suffering the needless loss of a loved one.

It would be well for all of us to keep in mind that for every human being, the road to an aging society begins on the date of birth, and unless God intervenes in the meantime - we all get there without exception.

Martin Niemoller, the German Protestant leader and member of anti-Hitler opposition, wrote the following:

> In Germany they came first for the Communists,
> And I didn't speak up because I wasn't a Communist.
> Then they came for the Jews
> And I didn't speak up because I wasn't a Jew.
> Then they came for the trade unionists
> And I didn't speak up because I wasn't a trade unionist.
> Then they came for the Catholics
> And I didn't speak up because I was a Protestant
> Then they came for me, and by that time
> Nobody was left to speak up.

The following underlined words have been substituted for Martin Niemoller's original words:

> In America they came first for the helpless
> And I didn't speak up because I wasn't helpless
> Then they came for the sick and disabled
> And I didn't speak up because I wasn't sick and disabled
> Then they came for the poor
> and I didn't speak up because I wasn't poor
> Then they came for the old people
> And I didn't speak up because I was young
> Then they came for me and by that time
> Nobody was left to speak up.

This sounds horrible, doesn't it?

Many doctors and other writers mention euthanasia and such things as a changing society from "a right to die," to "a duty to die." Can you see what will happen if we don't speak up? Many Medicare beneficiaries believe the founding steps have already been laid with DRG's and PPS being used as building blocks. If, and when, a trend toward euthanasia becomes real, no one will be excepted.

APPENDIX A

Source: The Repository, Canton, Ohio, October 22, 1987

A-10 The Repository Canton, Ohio Thursday, Oct. 22, 1987

Review: 22,000 lives lost yearly with poor Medicare treatment

WASHINGTON (AP) — A peer review system is uncovering hundreds of thousands of instances in which Medicare patients received dangerously poor care, some of it fatal, according to statistics released at a House hearing.

Records from the peer review organizations hired to monitor the performance of doctors and hospitals in the Medicare program indicate there may be nearly 900,000 cases of life-threatening treatment annually, Rep. Ted Weiss, D-N.Y., said Tuesday.

"Although the majority of Medicare patients receive safe treatment, a small percentage of negligent hospitals and doctors has created life-threatening risks" for many beneficiaries, said Weiss, chairman of the Government Operations subcommittee on human resources and intergovernmental relations.

The congressman said peer review organizations had screened 1.6 million Medicare hospital admissions as of last July and found 3,288 avoidable deaths.

With total Medicare hospital admissions at about 11 million a yecr, "there may potentially be 22,000 avoidable deaths, is that correct?" Weiss asked Dr. William Roper, head of the Health Care Financing Administration.

"That's the way the math works, but that kind of projection has to be done with great care . . . and assumptions drawn cautiously," Roper replied.

The 3-year-old peer review system began to focus on quality of care in 1986, using six screening criteria, including avoidable deaths, avoidable infections, discharges of unstable patients and inadequate planning for follow-up care.

"If you look only at the unduplicated number of cases reviewed, you still have 891,000 instances of dangerous care." Weiss said. He asked how HCFA plans to reduce the number.

Roper said the agency will publish regulations on substandard care within the next few weeks, making it easier for the peer review organizations to judge their colleagues. He said the reviews are the primary way to improve care in the system.

Roper also said the organizations are set to begin a study of hospital readmissions within 31 days to make sure a new prospective payment system based on diagnosis, rather than days of care provided, is not prompting hospitals to discharge patients too soon.

"I don't believe it's a widespread, serious problem," Roper said. "Any is too many, though."

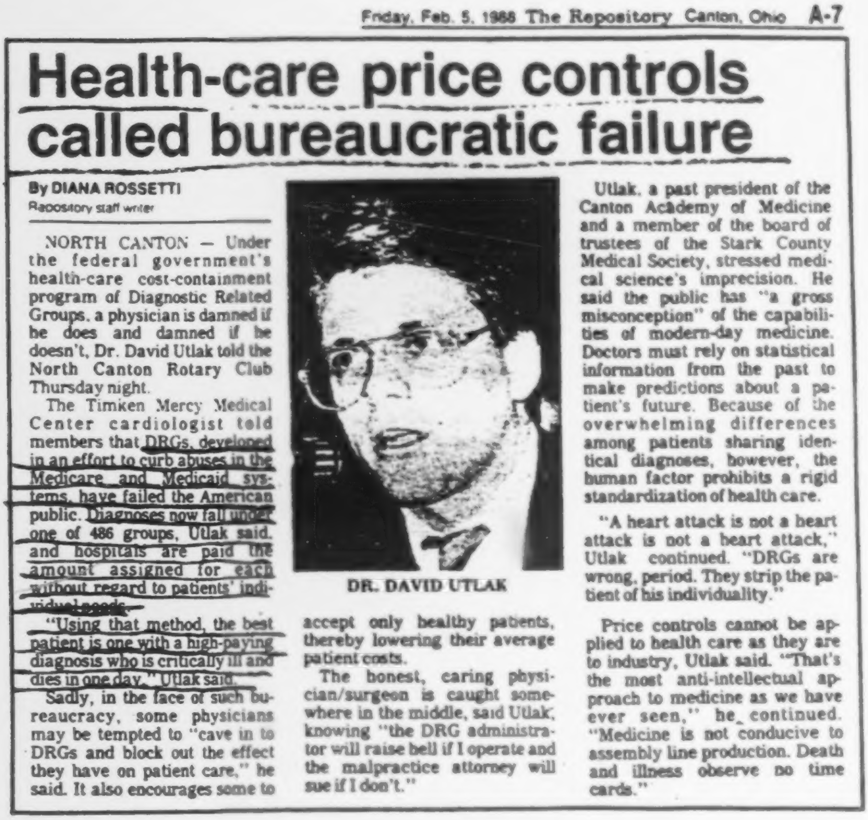
He added that HCFA has seen no evidence so far that the new payment system is harming patients.

Weiss cited the following statistics in the five screening areas besides avoidable deaths, all based on the peer-reviews of 1.6 million admissions:

- 58,582 definite cases of inadequate discharge planning for follow-up physical, emotional or psychological care. Projection to all Medicare admissions: 393,800 cases a year.
- 34,596 definite cases of patients unstable when they are discharged. Projection to all Medicare admissions: 232,000 cases.
- 30,172 cases of avoidable infections. Projection to all Medicare admissions: 198,000 cases.
- 1,947 cases of a patient's unscheduled return to surgery for the same condition as the previous operation or to correct a problem arising from the initial operation. Projection to all Medicare admissions: 12,100 cases.
- 22,269 cases of trauma suffered in the hospital, including medication errors and the unplanned removal or repair of a normal organ. Projection to all Medicare admissions: 149,600 cases.

Richard Kusserow, inspector general of the Department of Health and Human Services, said the agency is tougher on doctors who commit crimes than on those who are incompetent. He suggested making it easier to exclude doctors from the Medicare program.

Penalties now range from exclusion to monetary sanctions that amount to no more than "traffic tickets" for administering substandard health care, he said.



Friday, Feb. 5, 1988 The Repository Canton, Ohio A-7

Health-care price controls called bureaucratic failure

By DIANA ROSSETTI
Repository staff writer

NORTH CANTON — Under the federal government's health-care cost-containment program of Diagnostic Related Groups, a physician is damned if he does and damned if he doesn't, Dr. David Utlak told the North Canton Rotary Club Thursday night.

The Timken Mercy Medical Center cardiologist told members that DRGs, developed in an effort to curb abuses in the Medicare and Medicaid systems, have failed the American public. Diagnoses now fall under one of 486 groups, Utlak said, and hospitals are paid the amount assigned for each without regard to patients' individual needs.

"Using that method, the best patient is one with a high-paying diagnosis who is critically ill and dies in one day," Utlak said.

Sadly, in the face of such bureaucracy, some physicians may be tempted to "cave in to DRGs and block out the effect they have on patient care," he said. It also encourages some to accept only healthy patients, thereby lowering their average patient costs.

DR. DAVID UTLAK

The honest, caring physician/surgeon is caught somewhere in the middle, said Utlak, knowing "the DRG administrator will raise hell if I operate and the malpractice attorney will sue if I don't."

Utlak, a past president of the Canton Academy of Medicine and a member of the board of trustees of the Stark County Medical Society, stressed medical science's imprecision. He said the public has "a gross misconception" of the capabilities of modern-day medicine. Doctors must rely on statistical information from the past to make predictions about a patient's future. Because of the overwhelming differences among patients sharing identical diagnoses, however, the human factor prohibits a rigid standardization of health care.

"A heart attack is not a heart attack is not a heart attack," Utlak continued. "DRGs are wrong, period. They strip the patient of his individuality."

Price controls cannot be applied to health care as they are to industry, Utlak said. "That's the most anti-intellectual approach to medicine as we have ever seen," he continued. "Medicine is not conducive to assembly line production. Death and illness observe no time cards."

APPENDIX B

Source: The Repository, Canton, Ohio, Friday, February 5, 1988

APPENDIX C (also continued on next page)

Source: The Repository, Canton, Ohio, February 21, 1988

Note: Although this article deals first with abortion, it leads into a discussion on euthanasia and/or of Medicare patients.

Abortion is opposed by

By REBECCA CLOVER
Repository religion writer

Dr. Gregory Rutecki sees a connection between a devaluing of life in the womb and arbitrary decisions on who lives and who dies outside the womb.

In some foreign countries, including Great Britain and Poland, kidney dialysis is unavailable after a certain age, usually late middle age.

In these same countries, abortion on demand has been a reality for decades.

Rutecki, a kidney specialist, and a fellow physician, Dr. Chester Bartram, are among those in the local medical community who are opposed to free exercise of abortion. Both men are on active status at Aultman Hospital, which has been targeted by anti-abortion forces in recent months.

Rutecki and Bartram are Christians, and their opposition to abortion is based on Scriptures that they believe ban the practice.

Beyond these beliefs, they fear what they see as the moral consequences of abortion in American society.

"We're relative babes on the abortion issue. The only reason we haven't seen these trends yet is because abortion is a relatively recent phenomenon for us," Rutecki said. "The concept of the life not worth being lived was introduced into American society in 1973 by the liberalization of abortion."

Rutecki points to incidents such as decisions to allow severely handicapped children die and to recent rules by Medicare to limit patients' hospital time, as possible signs that a trend is forming.

Bartram fears that the devaluation of life in the womb will lead to the devaluation of all life.

DR. GREGORY RUTECKI

JACQUELINE HIBBARD

"If a society can single out a given population as too young, saying that life is less than human, by that arbitrary standard, it can single out any kind of life," said Bartram, an internist who also specializes in infectious disease.

The full effects of abortion will be seen several generations from now, the doctors believe. In future decades, people raised in a society that performs abortions will find it easier to accept the withholding of treatment from older patients or from physically and mentally handicapped people.

The practice has long-term financial consequences, too, the doctors argue. As the baby boom generation moves toward old age, the number of younger people paying into Social Security will be smaller by the millions of people who won't be born because of abortion, Bartram said.

Jackie Hibbard, a registered nurse who is director of nursing at Manor Care Nursing Center in Jackson Township, fears that attitudes toward unborn fetuses could affect attitudes toward other life.

"I'm very concerned. As a nurse in a geriatric center, I have to be," Mrs. Hibbard said.

She is outspoken on pro-life issues because the unborn child can't speak for itself, she explained.

"It has to do with your beliefs in the sanctity of life," she said. "Someone has to protect the unborn child. They have no voice for themselves, so those of us here who have the conviction that the sanctity of life is important have to speak for them."

Both men spoke highly of Aultman Hospital and said it has a deservedly excellent reputation in the medical community. Their opposition to the practice of abortion is not meant as an attack on the hospital or on their colleagues who practice abortion or support its legal availability.

If the practice of abortion should cease at the hospital, Bartram concedes it would be a small victory in a large war.

"Aultman Hospital is a symbol more than a fight," he said. "The problem is not Aultman, and if I focus all my energy as a pro-life person on Aultman, it's misplaced."

Bartram believes political activity is a more effective approach in the broader struggle against abortion on demand. Voting for pro-life politicians and supporting the appointment of pro-life Supreme Court justices is part of the long-

APPENDIX C (continued)

3 health professionals

DR. CHESTER BARTRAM

Medical community split over issue

Since legal abortion became widely available in 1972, it has been one of the most hotly debated issues of modern times.

In the Roe vs. Wade decision, the U.S. Supreme Court ruled that abortion is a matter of privacy between physician and patient.

Within the medical community, though, abortion does not have universal support. Pro-life physicians and nurses have been among abortion's opponents.

When Aultman Hospital became the target of pro-life activists late last year, leaders of the protest raised questions about the support the hospital's policies have among local health-care professionals.

Two physicians and a nurse readily agreed to be interviewed by The Repository about their pro-life beliefs. Efforts to find local physicians to speak on the pro-choice side failed.

Dr. Stephen DeVoe, an obstetrician and gynecologist in practice in Columbus, agreed to present the pro-choice position. DeVoe is legislative liaison for the Ohio section of the American College of Obstetricians and Gynecologists.

term strategy of anti-abortion forces, he explained.

"We're not going to see Roe vs. Wade reversed," he said. "But I believe we will have the power to chip away at it."

Another approach to limiting abortion is educating women and providing them with alternatives for an unwanted pregnancy, medical pro-life activists believe.

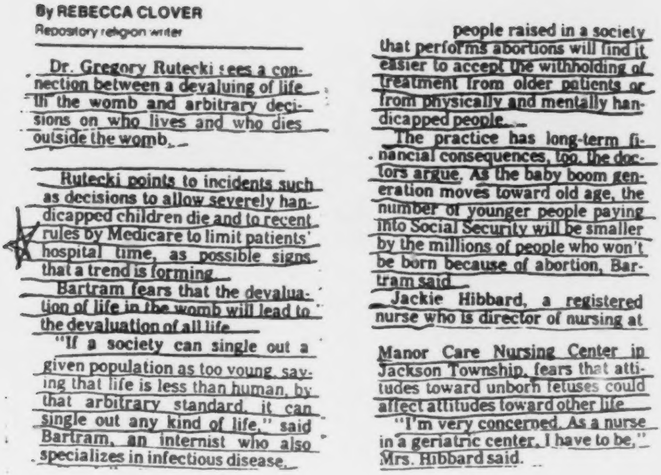
Mrs. Hibbard serves on the board of the Right to Life Educational Foundation of Stark County. The foundation works to inform the public of its beliefs that life starts at conception, Mrs. Hibbard said.

"People close their minds to it," said Mrs. Hibbard. "People don't want to see the fetus and know life is there. They don't want it to touch them."

The doctors and Mrs. Hibbard support programs such as the Crisis Pregnancy Support Center of Stark County. Bartram is on the center board.

The financial and psychological support offered by the center to women with unwanted pregnancies hasn't always been in place, Bartram said.

"The Christian community had a less than helpful attitude" in 1973, he said. "I feel the Judeo-Christian support for these girls that is there today was not there at the time."



By REBECCA CLOVER
Repository religion writer

Dr. Gregory Rutecki sees a connection between a devaluing of life in the womb and arbitrary decisions on who lives and who dies outside the womb.

Rutecki points to incidents such as decisions to allow severely handicapped children die and to recent rules by Medicare to limit patients' hospital time, as possible signs that a trend is forming.

Bartram fears that the devaluation of life in the womb will lead to the devaluation of all life.

"If a society can single out a given population as too young, saying that life is less than human, by that arbitrary standard, it can single out any kind of life," said Bartram, an internist who also specializes in infectious disease.

people raised in a society that performs abortions will find it easier to accept the withholding of treatment from older patients or from physically and mentally handicapped people.

The practice has long-term financial consequences, too, the doctors argue. As the baby boom generation moves toward old age, the number of younger people paying into Social Security will be smaller by the millions of people who won't be born because of abortion, Bartram said.

Jackie Hibbard, a registered nurse who is director of nursing at Manor Care Nursing Center in Jackson Township, fears that attitudes toward unborn fetuses could affect attitudes toward other life.

"I'm very concerned. As a nurse in a geriatric center, I have to be," Mrs. Hibbard said.

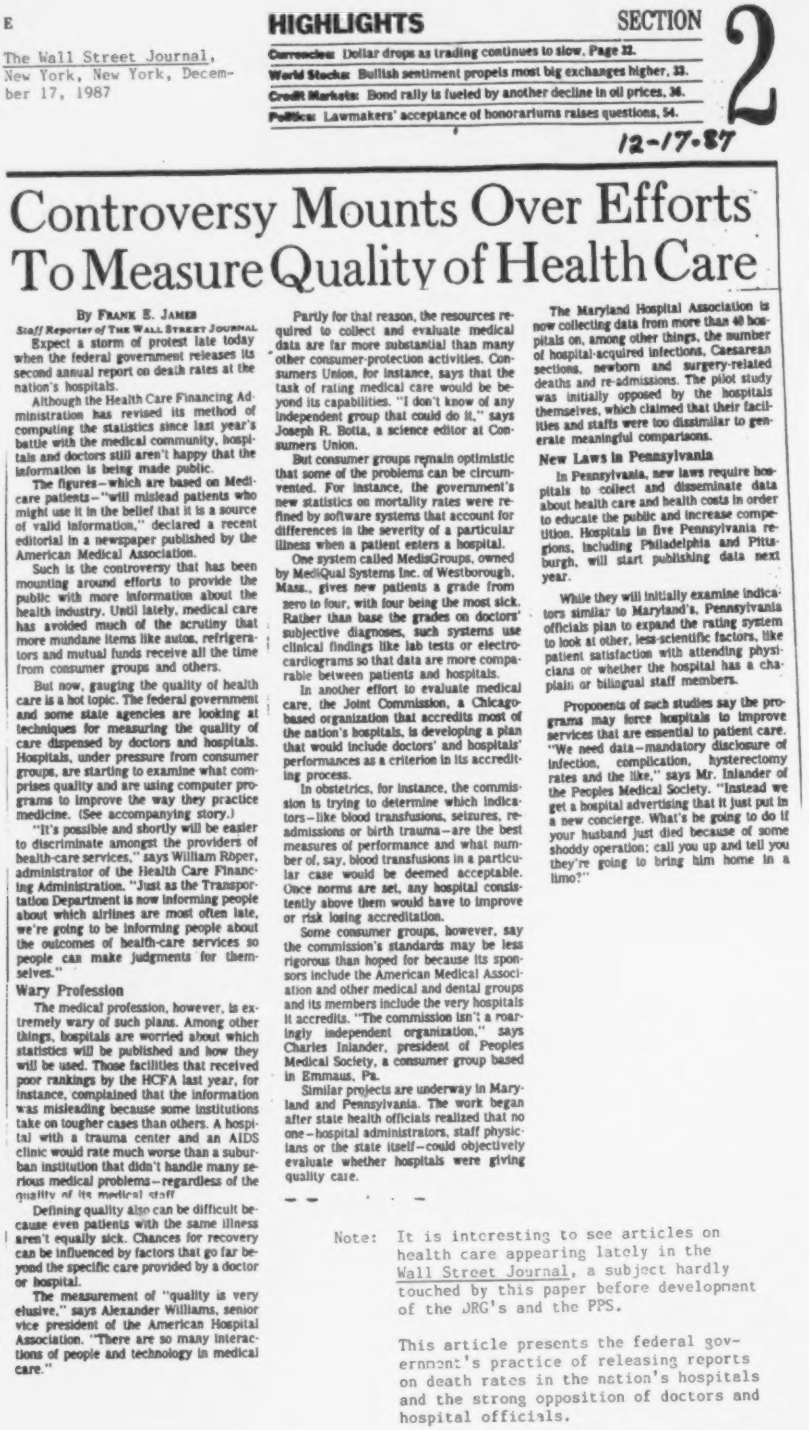
APPENDIX D

Source: The Repository, Canton, Ohio, February 21, 1988

Note: Although this article deals with abortion primarily, it really delves further into the tragic deaths caused to the handicapped and the elderly Medicare beneficiaries due to Medicare guidelines which limit patients' hospital time.

APPENDIX E

Source: The Wall Street Journal, New York, New York, December 17, 1987



HIGHLIGHTS SECTION 2

Currencies: Dollar drops as trading continues to slow, Page 32.
World Stocks: Bullish sentiment propels most big exchanges higher, 33.
Credit Markets: Bond rally is fueled by another decline in oil prices, 36.
Politics: Lawmakers' acceptance of honorariums raises questions, 54.

12-17-87

Controversy Mounts Over Efforts To Measure Quality of Health Care

By FRANK E. JAMES
Staff Reporter of THE WALL STREET JOURNAL

Expect a storm of protest late today when the federal government releases its second annual report on death rates at the nation's hospitals.

Although the Health Care Financing Administration has revised its method of computing the statistics since last year's battle with the medical community, hospitals and doctors still aren't happy that the information is being made public.

The figures—which are based on Medicare patients—"will mislead patients who might use it in the belief that it is a source of valid information," declared a recent editorial in a newspaper published by the American Medical Association.

Such is the controversy that has been mounting around efforts to provide the public with more information about the health industry. Until lately, medical care has avoided much of the scrutiny that more mundane items like autos, refrigerators and mutual funds receive all the time from consumer groups and others.

But now, gauging the quality of health care is a hot topic. The federal government and some state agencies are looking at techniques for measuring the quality of care dispensed by doctors and hospitals. Hospitals, under pressure from consumer groups, are starting to examine what comprises quality and are using computer programs to improve the way they practice medicine. (See accompanying story.)

"It's possible and shortly will be easier to discriminate amongst the providers of health-care services," says William Roper, administrator of the Health Care Financing Administration. "Just as the Transportation Department is now informing people about which airlines are most often late, we're going to be informing people about the outcomes of health-care services so people can make judgments for themselves."

Wary Profession

The medical profession, however, is extremely wary of such plans. Among other things, hospitals are worried about which statistics will be published and how they will be used. Those facilities that received poor rankings by the HCFA last year, for instance, complained that the information was misleading because some institutions take on tougher cases than others. A hospital with a trauma center and an AIDS clinic would rate much worse than a suburban institution that didn't handle many serious medical problems—regardless of the quality of its medical staff

Defining quality also can be difficult because even patients with the same illness aren't equally sick. Chances for recovery can be influenced by factors that go far beyond the specific care provided by a doctor or hospital.

The measurement of "quality is very elusive," says Alexander Williams, senior vice president of the American Hospital Association. "There are so many interactions of people and technology in medical care."

Partly for that reason, the resources required to collect and evaluate medical data are far more substantial than many other consumer-protection activities. Consumers Union, for instance, says that the task of rating medical care would be beyond its capabilities. "I don't know of any independent group that could do it," says Joseph R. Botta, a science editor at Consumers Union.

But consumer groups remain optimistic that some of the problems can be circumvented. For instance, the government's new statistics on mortality rates were refined by software systems that account for differences in the severity of a particular illness when a patient enters a hospital.

One system called MedisGroups, owned by MediQual Systems Inc. of Westborough, Mass., gives new patients a grade from zero to four, with four being the most sick. Rather than base the grades on doctors' subjective diagnoses, such systems use clinical findings like lab tests or electrocardiograms so that data are more comparable between patients and hospitals.

In another effort to evaluate medical care, the Joint Commission, a Chicago-based organization that accredits most of the nation's hospitals, is developing a plan that would include doctors' and hospitals' performances as a criterion in its accrediting process.

In obstetrics, for instance, the commission is trying to determine which indicators—like blood transfusions, seizures, readmissions or birth trauma—are the best measures of performance and what number of, say, blood transfusions in a particular case would be deemed acceptable. Once norms are set, any hospital consistently above them would have to improve or risk losing accreditation.

Some consumer groups, however, say the commission's standards may be less rigorous than hoped for because its sponsors include the American Medical Association and other medical and dental groups and its members include the very hospitals it accredits. "The commission isn't a roaringly independent organization," says Charles Inlander, president of Peoples Medical Society, a consumer group based in Emmaus, Pa.

Similar projects are underway in Maryland and Pennsylvania. The work began after state health officials realized that no one—hospital administrators, staff physicians or the state itself—could objectively evaluate whether hospitals were giving quality care.

The Maryland Hospital Association is now collecting data from more than 40 hospitals on, among other things, the number of hospital-acquired infections, Caesarean sections, newborn and surgery-related deaths and re-admissions. The pilot study was initially opposed by the hospitals themselves, which claimed that their facilities and staffs were too dissimilar to generate meaningful comparisons.

New Laws in Pennsylvania

In Pennsylvania, new laws require hospitals to collect and disseminate data about health care and health costs in order to educate the public and increase competition. Hospitals in five Pennsylvania regions, including Philadelphia and Pittsburgh, will start publishing data next year.

While they will initially examine indicators similar to Maryland's, Pennsylvania officials plan to expand the rating system to look at other, less-scientific factors, like patient satisfaction with attending physicians or whether the hospital has a chaplain or bilingual staff members.

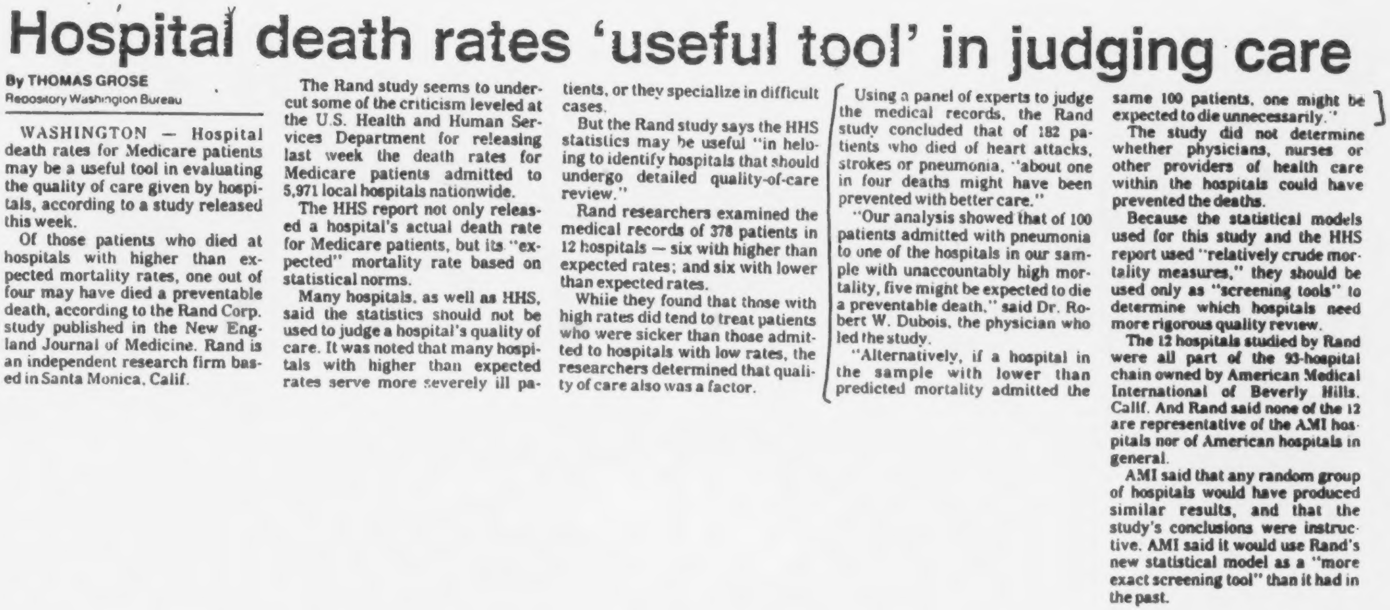
Proponents of such studies say the programs may force hospitals to improve services that are essential to patient care. "We need data—mandatory disclosure of infection, complication, hysterectomy rates and the like," says Mr. Inlander of the Peoples Medical Society. "Instead we get a hospital advertising that it just put in a new concierge. What's he going to do if your husband just died because of some shoddy operation: call you up and tell you they're going to bring him home in a limo?"

Note: It is interesting to see articles on health care appearing lately in the Wall Street Journal, a subject hardly touched by this paper before development of the DRG's and the PPS.

This article presents the federal government's practice of releasing reports on death rates in the nation's hospitals and the strong opposition of doctors and hospital officials.

APPENDIX F

Source: The Repository, Canton, Ohio, December 26, 1987



Hospital death rates 'useful tool' in judging care

By THOMAS GROSE
Repository Washington Bureau

WASHINGTON — Hospital death rates for Medicare patients may be a useful tool in evaluating the quality of care given by hospitals, according to a study released this week.

Of those patients who died at hospitals with higher than expected mortality rates, one out of four may have died a preventable death, according to the Rand Corp. study published in the New England Journal of Medicine. Rand is an independent research firm based in Santa Monica, Calif.

The Rand study seems to undercut some of the criticism leveled at the U.S. Health and Human Services Department for releasing last week the death rates for Medicare patients admitted to 5,971 local hospitals nationwide.

The HHS report not only released a hospital's actual death rate for Medicare patients, but its "expected" mortality rate based on statistical norms.

Many hospitals, as well as HHS, said the statistics should not be used to judge a hospital's quality of care. It was noted that many hospitals with higher than expected rates serve more severely ill patients, or they specialize in difficult cases.

But the Rand study says the HHS statistics may be useful "in helping to identify hospitals that should undergo detailed quality-of-care review."

Rand researchers examined the medical records of 378 patients in 12 hospitals — six with higher than expected rates; and six with lower than expected rates.

While they found that those with high rates did tend to treat patients who were sicker than those admitted to hospitals with low rates, the researchers determined that quality of care also was a factor.

Using a panel of experts to judge the medical records, the Rand study concluded that of 182 patients who died of heart attacks, strokes or pneumonia, "about one in four deaths might have been prevented with better care."

"Our analysis showed that of 100 patients admitted with pneumonia to one of the hospitals in our sample with unaccountably high mortality, five might be expected to die a preventable death," said Dr. Robert W. Dubois, the physician who led the study.

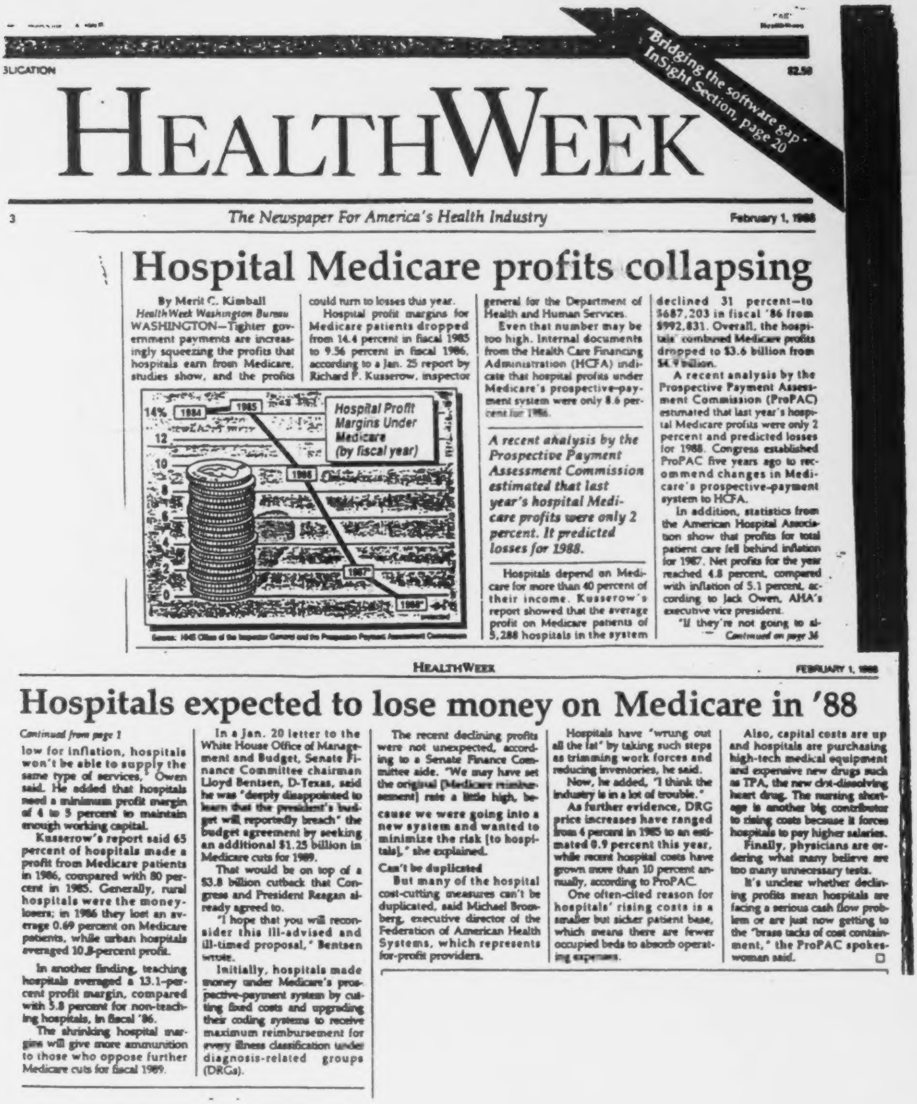
"Alternatively, if a hospital in the sample with lower than predicted mortality admitted the same 100 patients, one might be expected to die unnecessarily."

The study did not determine whether physicians, nurses or other providers of health care within the hospitals could have prevented the deaths.

Because the statistical models used for this study and the HHS report used "relatively crude mortality measures," they should be used only as "screening tools" to determine which hospitals need more rigorous quality review.

The 12 hospitals studied by Rand were all part of the 93-hospital chain owned by American Medical International of Beverly Hills, Calif. And Rand said none of the 12 are representative of the AMI hospitals nor of American hospitals in general.

AMI said that any random group of hospitals would have produced similar results, and that the study's conclusions were instructive. AMI said it would use Rand's new statistical model as a "more exact screening tool" than it had in the past.



3LICATION $2.50

HEALTHWEEK

3 The Newspaper For America's Health Industry February 1, 1988

Bridging the software gap · InSight Section, page 20

Hospital Medicare profits collapsing

By Merit C. Kimball
HealthWeek Washington Bureau

WASHINGTON—Tighter government payments are increasingly squeezing the profits that hospitals earn from Medicare, studies show, and the profits could turn to losses this year.

Hospital profit margins for Medicare patients dropped from 14.4 percent in fiscal 1985 to 9.56 percent in fiscal 1986, according to a Jan. 25 report by Richard P. Kusserow, inspector general for the Department of Health and Human Services.

Source: HHS Office of the Inspector General and the Prospective Payment Assessment Commission

Even that number may be too high. Internal documents from the Health Care Financing Administration (HCFA) indicate that hospital profits under Medicare's prospective-payment system were only 8.6 percent for 1986.

A recent analysis by the Prospective Payment Assessment Commission estimated that last year's hospital Medicare profits were only 2 percent. It predicted losses for 1988.

Hospitals depend on Medicare for more than 40 percent of their income. Kusserow's report showed that the average profit on Medicare patients of 5,288 hospitals in the system declined 31 percent—to $687,203 in fiscal '86 from $992,831. Overall, the hospitals' combined Medicare profits dropped to $3.6 billion from $4.9 billion.

A recent analysis by the Prospective Payment Assessment Commission (ProPAC) estimated that last year's hospital Medicare profits were only 2 percent and predicted losses for 1988. Congress established ProPAC five years ago to recommend changes in Medicare's prospective-payment system to HCFA.

In addition, statistics from the American Hospital Association show that profits for total patient care fell behind inflation for 1987. Net profits for the year reached 4.8 percent, compared with inflation of 5.1 percent, according to Jack Owen, AHA's executive vice president.

"If they're not going to al-

Continued on page 36

HEALTHWEEK FEBRUARY 1, 1988

Hospitals expected to lose money on Medicare in '88

Continued from page 1

low for inflation, hospitals won't be able to supply the same type of services," Owen said. He added that hospitals need a minimum profit margin of 4 to 5 percent to maintain enough working capital.

Kusserow's report said 65 percent of hospitals made a profit from Medicare patients in 1986, compared with 80 percent in 1985. Generally, rural hospitals were the money-losers; in 1986 they lost an average 0.69 percent on Medicare patients, while urban hospitals averaged 10.8-percent profit.

In another finding, teaching hospitals averaged a 13.1-percent profit margin, compared with 5.8 percent for non-teaching hospitals, in fiscal '86.

The shrinking hospital margins will give more ammunition to those who oppose further Medicare cuts for fiscal 1989.

In a Jan. 20 letter to the White House Office of Management and Budget, Senate Finance Committee chairman Lloyd Bentsen, D-Texas, said he was "deeply disappointed to learn that the president's budget will reportedly breach" the budget agreement by seeking an additional $1.25 billion in Medicare cuts for 1989.

That would be on top of a $3.8 billion cutback that Congress and President Reagan already agreed to.

"I hope that you will reconsider this ill-advised and ill-timed proposal," Bentsen wrote.

Initially, hospitals made money under Medicare's prospective-payment system by cutting fixed costs and upgrading their coding systems to receive maximum reimbursement for every illness classification under diagnosis-related groups (DRGs).

The recent declining profits were not unexpected, according to a Senate Finance Committee aide. "We may have set the original [Medicare reimbursement] rate a little high, because we were going into a new system and wanted to minimize the risk [to hospitals]," she explained.

Can't be duplicated

But many of the hospital cost-cutting measures can't be duplicated, said Michael Bromberg, executive director of the Federation of American Health Systems, which represents for-profit providers.

Hospitals have "wrung out all the fat" by taking such steps as trimming work forces and reducing inventories, he said.

Now, he added, "I think the industry is in a lot of trouble."

As further evidence, DRG price increases have ranged from 4 percent in 1985 to an estimated 0.9 percent this year, while recent hospital costs have grown more than 10 percent annually, according to ProPAC.

One often-cited reason for hospitals' rising costs is a smaller but sicker patient base, which means there are fewer occupied beds to absorb operating expenses.

Also, capital costs are up and hospitals are purchasing high-tech medical equipment and expensive new drugs such as TPA, the new clot-dissolving heart drug. The nursing shortage is another big contributor to rising costs because it forces hospitals to pay higher salaries.

Finally, physicians are ordering what many believe are too many unnecessary tests.

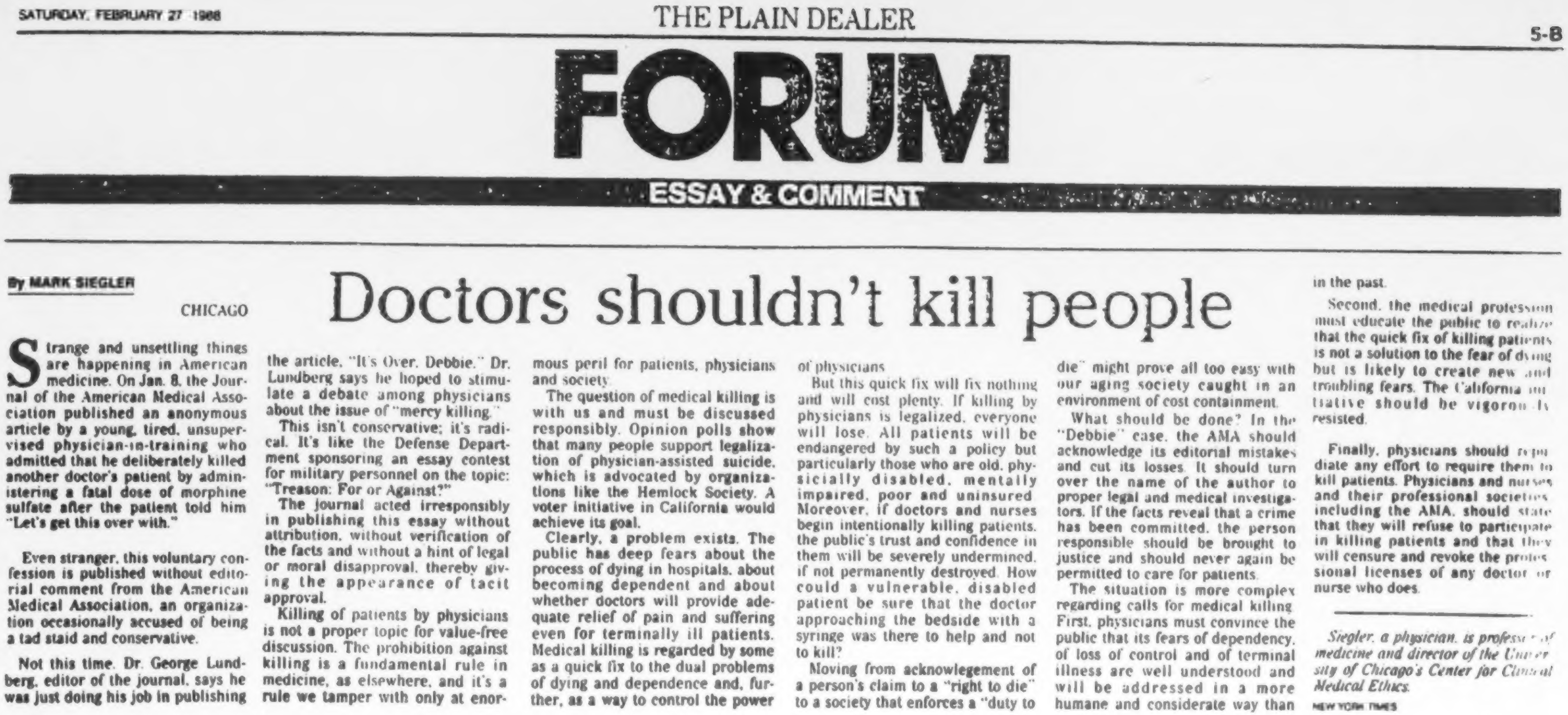
It's unclear whether declining profits mean hospitals are facing a serious cash flow problem or are just now getting to the "brass tacks of cost containment," the ProPAC spokeswoman said. ☐

APPENDIX G

Source: Health Week, Washington, D.C., February 1, 1988

Note: This article warns that hospital profit margins from Medicare patients is touching bottom because payments by Medicare are too low.

Therefore, in my opinion, there should be no Medicare cuts in 1989 in order to save Medicare patients from poor quality medical care and needless deaths.



SATURDAY, FEBRUARY 27 1988

THE PLAIN DEALER

5-B

FORUM

ESSAY & COMMENT

Doctors shouldn't kill people

By MARK SIEGLER

CHICAGO

Strange and unsettling things are happening in American medicine. On Jan. 8, the Journal of the American Medical Association published an anonymous article by a young, tired, unsupervised physician-in-training who admitted that he deliberately killed another doctor's patient by administering a fatal dose of morphine sulfate after the patient told him "Let's get this over with."

Even stranger, this voluntary confession is published without editorial comment from the American Medical Association, an organization occasionally accused of being a tad staid and conservative.

Not this time. Dr. George Lundberg, editor of the journal, says he was just doing his job in publishing the article, "It's Over, Debbie." Dr. Lundberg says he hoped to stimulate a debate among physicians about the issue of "mercy killing."

This isn't conservative; it's radical. It's like the Defense Department sponsoring an essay contest for military personnel on the topic: "Treason: For or Against?"

The journal acted irresponsibly in publishing this essay without attribution, without verification of the facts and without a hint of legal or moral disapproval, thereby giving the appearance of tacit approval.

Killing of patients by physicians is not a proper topic for value-free discussion. The prohibition against killing is a fundamental rule in medicine, as elsewhere, and it's a rule we tamper with only at enormous peril for patients, physicians and society.

The question of medical killing is with us and must be discussed responsibly. Opinion polls show that many people support legalization of physician-assisted suicide, which is advocated by organizations like the Hemlock Society. A voter initiative in California would achieve its goal.

Clearly, a problem exists. The public has deep fears about the process of dying in hospitals, about becoming dependent and about whether doctors will provide adequate relief of pain and suffering even for terminally ill patients. Medical killing is regarded by some as a quick fix to the dual problems of dying and dependence and, further, as a way to control the power of physicians.

But this quick fix will fix nothing and will cost plenty. If killing by physicians is legalized, everyone will lose. All patients will be endangered by such a policy but particularly those who are old, physically disabled, mentally impaired, poor and uninsured.

Moreover, if doctors and nurses begin intentionally killing patients, the public's trust and confidence in them will be severely undermined, if not permanently destroyed. How could a vulnerable, disabled patient be sure that the doctor approaching the bedside with a syringe was there to help and not to kill?

Moving from acknowlegement of a person's claim to a "right to die" to a society that enforces a "duty to die" might prove all too easy with our aging society caught in an environment of cost containment.

What should be done? In the "Debbie" case, the AMA should acknowledge its editorial mistakes and cut its losses. It should turn over the name of the author to proper legal and medical investigators. If the facts reveal that a crime has been committed, the person responsible should be brought to justice and should never again be permitted to care for patients.

The situation is more complex regarding calls for medical killing. First, physicians must convince the public that its fears of dependency, of loss of control and of terminal illness are well understood and will be addressed in a more humane and considerate way than in the past.

Second, the medical profession must educate the public to realize that the quick fix of killing patients is not a solution to the fear of dying but is likely to create new and troubling fears. The California initiative should be vigorously resisted.

Finally, physicians should repudiate any effort to require them to kill patients. Physicians and nurses and their professional societies, including the AMA, should state that they will refuse to participate in killing patients and that they will censure and revoke the professional licenses of any doctor or nurse who does.

Siegler, a physician, is professor of medicine and director of the University of Chicago's Center for Clinical Medical Ethics.

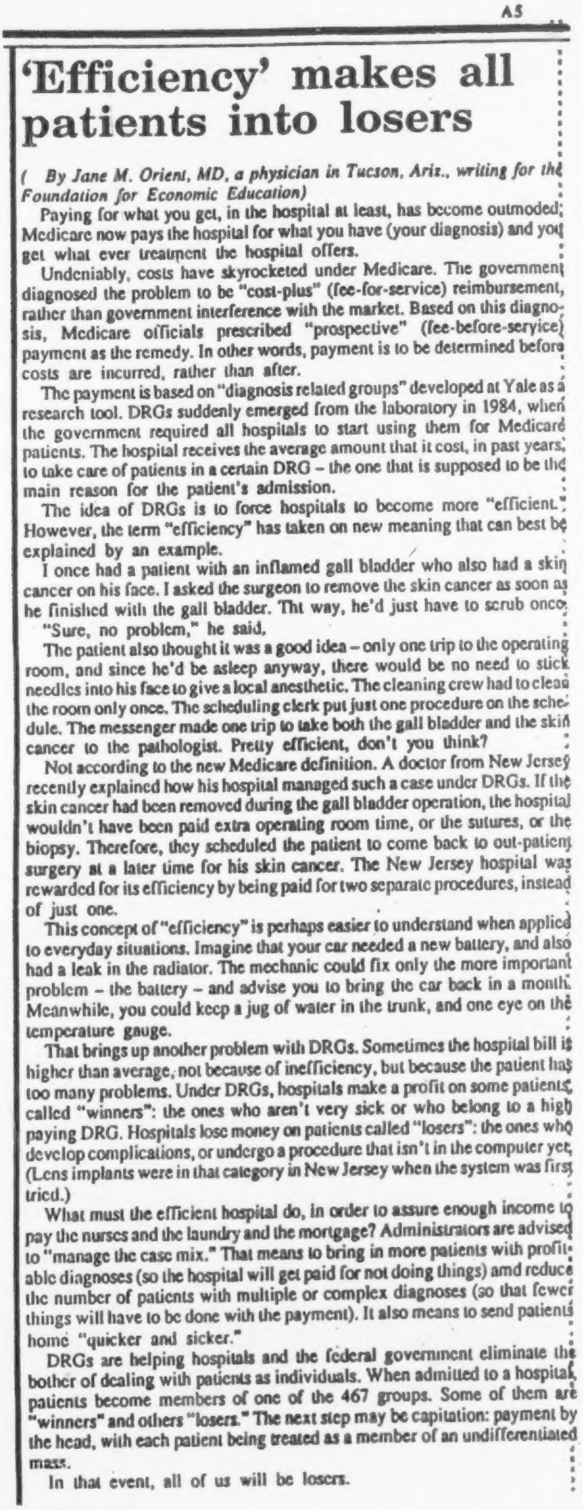
NEW YORK TIMES

APPENDIX H

Source: The Plain Dealer, Cleveland, Ohio, February 27, 1988

APPENDIX I

Source: The Free Press, Canton, Ohio, August 23, 1987



AS

'Efficiency' makes all patients into losers

(By Jane M. Orient, MD, a physician in Tucson, Ariz., writing for the Foundation for Economic Education)

Paying for what you get, in the hospital at least, has become outmoded; Medicare now pays the hospital for what you have (your diagnosis) and you get what ever treatment the hospital offers.

Undeniably, costs have skyrocketed under Medicare. The government diagnosed the problem to be "cost-plus" (fee-for-service) reimbursement, rather than government interference with the market. Based on this diagnosis, Medicare officials prescribed "prospective" (fee-before-service) payment as the remedy. In other words, payment is to be determined before costs are incurred, rather than after.

The payment is based on "diagnosis related groups" developed at Yale as a research tool. DRGs suddenly emerged from the laboratory in 1984, when the government required all hospitals to start using them for Medicare patients. The hospital receives the average amount that it cost, in past years, to take care of patients in a certain DRG – the one that is supposed to be the main reason for the patient's admission.

The idea of DRGs is to force hospitals to become more "efficient." However, the term "efficiency" has taken on new meaning that can best be explained by an example.

I once had a patient with an inflamed gall bladder who also had a skin cancer on his face. I asked the surgeon to remove the skin cancer as soon as he finished with the gall bladder. Tht way, he'd just have to scrub once.

"Sure, no problem," he said.

The patient also thought it was a good idea – only one trip to the operating room, and since he'd be asleep anyway, there would be no need to stick needles into his face to give a local anesthetic. The cleaning crew had to clean the room only once. The scheduling clerk put just one procedure on the schedule. The messenger made one trip to take both the gall bladder and the skin cancer to the pathologist. Pretty efficient, don't you think?

Not according to the new Medicare definition. A doctor from New Jersey recently explained how his hospital managed such a case under DRGs. If the skin cancer had been removed during the gall bladder operation, the hospital wouldn't have been paid extra operating room time, or the sutures, or the biopsy. Therefore, they scheduled the patient to come back to out-patient surgery at a later time for his skin cancer. The New Jersey hospital was rewarded for its efficiency by being paid for two separate procedures, instead of just one.

This concept of "efficiency" is perhaps easier to understand when applied to everyday situations. Imagine that your car needed a new battery, and also had a leak in the radiator. The mechanic could fix only the more important problem – the battery – and advise you to bring the car back in a month. Meanwhile, you could keep a jug of water in the trunk, and one eye on the temperature gauge.

That brings up another problem with DRGs. Sometimes the hospital bill is higher than average, not because of inefficiency, but because the patient has too many problems. Under DRGs, hospitals make a profit on some patients, called "winners": the ones who aren't very sick or who belong to a high paying DRG. Hospitals lose money on patients called "losers": the ones who develop complications, or undergo a procedure that isn't in the computer yet. (Lens implants were in that category in New Jersey when the system was first tried.)

What must the efficient hospital do, in order to assure enough income to pay the nurses and the laundry and the mortgage? Administrators are advised to "manage the case mix." That means to bring in more patients with profitable diagnoses (so the hospital will get paid for not doing things) amd reduce the number of patients with multiple or complex diagnoses (so that fewer things will have to be done with the payment). It also means to send patients home "quicker and sicker."

DRGs are helping hospitals and the federal government eliminate the bother of dealing with patients as individuals. When admitted to a hospital, patients become members of one of the 467 groups. Some of them are "winners" and others "losers." The next step may be capitation: payment by the head, with each patient being treated as a member of an undifferentiated mass.

In that event, all of us will be losers.

Statement of Sister Sheila Lyne, Chairman of the Board of Trustees, Illinois Hospital Association

Thank you Mr. Chairman and members of the subcommittee for allowing me to present written testimony. I am Sister Sheila Lyne, President of Mercy Hospital and Medical Center in Chicago and Chairman of the Illinois Hospital Association Board of Trustees. I am also a former member of the Prospective Payment Assessment Commission.

The Illinois Hospital Association, which represents the hospitals of Illinois, is pleased to have this opportunity to express our concern with the Medicare prospective payment system.

According to Congressional Budget Office data, Chicago-area hospitals have lost 11.2 percent of their Medicare revenue since the prospective payment system was implemented. That revenue has gone to other states as windfall profits. This means that the typical Chicago hospital is now receiving about $400 less per case than it was five years ago. Rural Illinois hospitals are receiving almost 4 percent fewer dollars per case.

How has this happened? The hospitals of Illinois, and particularly Chicago, are not uniformly inefficient. Rather, they are the victims of a system that is built entirely on averages, that doesn't fully take into account the business circumstances of particular geographic areas, and that shortchanges some hospitals and overly rewards others.

Last year, Congress recognized that the cost of doing business is higher in some areas and cheaper in others, when it passed the Omnibus Budget Reconciliation Act (PL 100-203).

Yet, Illinois hospitals are still struggling; current adjustments to Prospective Payment System (PPS) rates are still inadequate. Costs have risen steadily during the five-year transition to national Medicare rates, while Medicare payments to Illinois hospitals have not. Marketbasket costs have increased 25.5 percent, while Medicare payment rates in Illinois have risen less than 1 percent. Medicare operating margins were less than zero in fiscal 1987 and will be sharply negative in 1988 and beyond, unless corrective action is taken. In 1988, Mercy Hospital expects to lose $250 per case on every Medicare patient.

Over the five years since PPS was implemented, hospitals have taken a disproportionate share of federal budget cuts. Health care received the largest cut in last year's budget, and hospitals represented the greatest proportion of those cuts. In last year's budget, Medicare received 36 percent of the budget cuts, but only represented 9 percent of the federal outlays.

This year the Administration is proposing $1.25 billion in Medicare cuts beyond last year's agreement. It further is suggesting that these cuts come mostly from teaching hospitals. The federal government's rationale for these proposed cuts is reports that the operating margins of teaching hospitals were abnormally high during the first years of PPS. I can tell you now that operating margins of teaching hospitals in Illinois have changed - from black ink to red. Any further cuts will only shortchange Medicare beneficiaries and the next generation of medical professionals.

Medicare payment rate increases over the past few years have been determined by federal budget necessity, without regard to the cost to provide those services. Hospitals are offered little predictability, especially when Medicare rate increases are substantially below and bear no relationship to actual economic increases. Medicare rate increases must keep up with the increasing costs to provide those services. We need your support in achieving adequate, equitable and predictable Medicare rates.

Currently before you is a ProPAC proposal, which recommends that greater emphasis be placed on cost rather than on length of stay for outlier payments. Illinois hospitals and the Illinois Hospital Association concur and suggest that the order of precedence be reversed - with cost outliers coming first. Hospitals across this country are far more adversely affected by especially intense, expensive cases than they are by several long but inexpensive stays. ProPAC further suggests movement to hospital-specific cost-to-charge ratios for calculating cost outlier payments. We agree.

In summary, we appreciated your efforts in the last federal budget toward increased equity in the prospective payment system. Yet, PPS's problems are far from solved. The payment system as it currently exists threatens the survival of many hospitals, especially those in locations where it costs more to operate a hospital. Medicare rates must keep up with the increasing costs to provide those services. Thank you.

THE HONORABLE ROBERT MATSUI
THE HONORABLE TONY COELHO
THE HONORABLE DON EDWARDS
AND
THE HONORABLE LEON PANETTA

STATEMENT ON MEDICARE'S PROPSPECTIVE PAYMENT SYSTEM

Submitted to the Ways and Means Committee
Subcommittee on Health

March 1, 1988

Mr. Chairman, members of the Subcommittee, we are pleased that you are holding this hearing to review the status and the impact of the Prospective Payment System (PPS). This hearing is especially valuable because you are looking at this issue as a policy matter, outside of the deficit-driven budgetary process. The deficit and budget process has continually forced Congress, as your Subcommittee knows all too well, to develop annual spending cuts at the same time that you are overseeing and revising the policies of this complicated new payment system.

The Subcommittee has an appropriate array of expert witnesses to help you assess the national implications of PPS. Our intention is to focus on some of the distributional consequences of PPS: a system which has reallocated billions of Medicare dollars over the past five years among regions, states and hospitals. Specifically, we want to alert the Subcommittee to what has happened in the State of California in the transition from hospital-specific to national rates.

The transition from hospital specific rates to fully federal rates has had a dramatic redistributional impact. The California Association of Hospitals and Health Systems (CAHHS) estimated that the hospitals which serve Medicare beneficiaries in California received $352 million less under fully federal rates this year than they would have received if 100 percent hospital specific rates had been retained. This means that over $350 million dollars has been redistributed from California hospitals to other states and regions of the country simply as a result of the averaging system. Contrary to reports that hospitals are making profits from Medicare, many hospitals in our state are now operating in the red. In fact, based on data from 238 hospitals in California, over 50% had a negative Medicare operating margin in 1986.

To some extent, other adjustments in the system, such as the disproportionate share adjuster, the medical education adjuster, and outlier payments, make up some of this difference. As you know, we are now working with you, CAHHS, and the Congressional Budget Office to resolve the differences in estimates of the impact of these adjusters. So far, CAHHS and CBO analysts estimate that the differences in the estimates of outlier and disproportionate share adjusters account for some $58 million. However, that still leaves about $294 million that CAHHS estimates has been reallocated from hospitals serving Medicare beneficiaries in California to hospitals in other areas of the country. We will continue to work with CAHHS and CBO to further reconcile their estimates and arrive at a firm understanding of the impact of the transition on California hospitals.

It is especially important to note that these reallocations come at the same time as you have had to reduce overall the rate of increase in Medicare spending for hospital care. Thus, some of these institutions serving the elderly get a double hit---the impact of a policy reallocation and a budgetary cut.

The problem with those reallocations is that they are being made through a PPS system which, even with its several adjustments, does not account for all of the significant variability in hospital costs per discharge. A number of studies reveal that the adjustments account for only about two-thirds of the variability in hospital costs per discharge. We share the Subcommittee's desire to assure efficiency in service delivery and control over Medicare spending, but it does not appear possible at this time to determine fully whether the reallocations are being made on the basis of efficiency of operations or on factors outside of hospitals' control.

The need for appropriate equity adjustments is essential for the long term viability and fairness of the fully implemented medicare prospective payment system. The transition from hospital specific cost reimbursement to national standard payment amounts has redistributed billions of dollars among hospitals. While some of this transfer is appropriate, some is not. In fact, a recent study revealed that between 20% to 40% of the redistribution of medicare payment dollars appears to be unintended.

Last year, the full Committee proposed to address one element of the problem---the lack of an adjustment for non-labor cost difference among the areas in which hospitals are located. However, that provision was dropped in Conference, and a regional floor provision was developed.

Under the new provision, in regions with higher total (labor and non-labor) PPS standardized rates than the national average, the higher regional level is partially taken into account in setting payment rates for hospitals in that region.

Unfortunately, that provision uses total standardized amounts, while it is the variation in non-labor related costs that is of concern. As this Subcommittee knows, there is already an adjuster for labor-related price differences. In most cases, the regions qualifying under the new test are also those who would have qualified under the non-labor related adjustment. While the Pacific region has urban and rural non-labor related standardized amounts in excess of the national average by 11 and 16 percent respectively, it does not qualify for a regional floor adjuster based on total costs. That outcome is inequitable because it is the variation in non-labor costs that was the original issue the Ways and Means Committee sought to address.

We ask that the Subcommittee look carefully at the precision and distributional equity of the PPS system in meeting the need of financing services for the elderly and the disabled under Medicare. Those distributional consequences will be especially important in the next few years as aggregate budget reductions are implemented in the rate of increase in spending for hospital services. Aggregate, nationwide solutions are not sufficient. Beneficiaries do not receive services in the aggregate, and we ask you to develop appropriate adjusters to account for service needs in individual communities throughout the nation.

We look forward to working with you to assure an equitable and adequate Medicare program for all hospitals.

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

2000 K Street, N.W., Suite 800, Washington, D.C. 20006 (202) 822-9459

My name is James Roosevelt. As Chairman of the National Committee to Preserve Social Security and Medicare, I represent the organization's more than five million members, the majority of whom are seniors depending on Medicare for their health care coverage. The National Committee is deeply concerned that a further reduction in profits will panic hospitals into reducing quality of care, further shifting costs to beneficiaries and reducing access to health care, particularly in rural areas.

In the name of budget savings, Congress and the Administration have, for years, gone after hospitals with a vengeance. This effort could now backfire. A 14 percent profit margin in the first two years of PPS, 1984 and 1985, was excessively high. However, according to the Medicare Prospective Payment Assessment Commission (ProPAC), the profit margin, which dropped to eight percent in 1986, could have been as low as two percent in 1987 and may be negative in 1988. Furthermore, the profit margin varies greatly between types of hospitals, which means that some categories of hospitals are working with profit margins considerably lower than the average.

The implementation of the prospective payment system (PPS) revolutionized hospital economics, but the well-documented side-effects have been lower quality of care, shifting of costs to beneficiaries and reduced access to medical care. The National Committee fears that the hospital response to lower profit margins will only exacerbate these problems.

> **The National Committee urges Congress and the Administration to commit themselves to a fair reimbursement rate for hospitals rather than indiscriminate cuts for the sake of reducing the deficit. Two key changes needed are a severity of illness index and higher reimbursements for rural hospitals.**

QUALITY OF CARE

Under the prospective payment system, patients are released from the hospital as soon as the physician judges their condition is stabilized. An American Medical Association survey shows that many physicians feel pressured by the admitting hospital to discharge the patient as expeditiously as possible. More than 82,000 of these discharges (approximately 189 per Congressional District) were premature in 1986, based on a recent study by the Inspector General. Our concern is that even more pressure will be placed on the physician to release patients as soon as they become liabilities to financially struggling hospitals because they did not recover costs within the allotted days. For example, one of our members explained how a hospital official began "harassing" her to take her father home or place him in a nursing home at a point where he still had an IV in his arm, had a catheter, was on oxygen and was undergoing respiratory therapy three times a day. The family had him moved to a nursing home "where they were neither equipped or trained to care for the critically ill patient. He passed away 11 days later."

Hospitals are also trying to reduce the number of tests and procedures available to patients. We fear that this new budget squeeze may even tempt hospitals to avoid admitting the type of patient likely to develop complications due to multiple and chronic conditions. Such patients are likely to be the frail elderly. It is frightening when the delivery of health care is fused with financial management.

The significant shift from inpatient surgery to performing surgery on an outpatient basis, saves Medicare dollars, but it is an additional hardship on many seniors. The emphasis is on getting patients in before daybreak and out before nightfall. These rigid requirements sometimes do not adequately allow for flexibility when complications arise. One 68-year old member from Burlington, Washington, relayed this story about one hospital's hurry to release him with only one hour of recovery after surgery: "I was administered the anesthetic at approximately 1:30 P.M. At approximately 4:00 P.M. I came out of the anesthsia. I was in extreme pain but their main interest was to get me out of the hospital by 5:00 P.M. I later learned that the operation was more extensive then they or I had expected. It was found during the operation that there were two nodules on a cord and they were removed.... I was in no condition to be released by the hospital."

SHIFTING OF COST TO BENEFICIARIES

Not only are hospitals disharging patients as early as possible, but they are also shifting more care from inpatient to an outpatient basis. Where once patients would recover completely from surgery in the hospital, they now recover at home or in a nursing home. But at the same time that more beneficiaries need home health care or skilled nursing home care, the Administration has been trying to limit eligibility. The National Committee has received numerous letters from members who are very distressed to discover that their post-hospital care in a skilled nursing home facility was not covered by Medicare because the stay was deemed "not medically necessary." So what was previously paid for under Medicare as the patient stayed an additional few days in the hospital now often becomes costly out-of-pocket care paid for by the patient or the patient's family.

ACCESS TO CARE IN RURAL AREAS

The squeeze on hospitals has caused many facilities to close. The hardship is especially felt by small rural hospitals because a few costly cases can financially ruin a hospital with a low volume. Sometimes, this causes such hospitals to be very selective in whom they admit. As one member describes it: "My husband worked in the coal mines for 28 years. He is 72 years past. He went to Richwood hospital the 24, and his temperature was 103, they sent him home. He went to the hospital at Summersville the 25, and his bowels was running, and he was a very sick man, and he still is. They sent him home. Us old people are wondering why when we are badly sick we will not be put in a hospital."

The National Committee is also concerned that the closing of rural facilities will be a hardship on seniors living far from urban centers. According to one state's estimate, twenty-five percent of admissions to rural hospitals are on an emergency basis. If these rural facilities are forced to close, what will happen to patients, who in these dire situations, have to travel 50 or 100 miles before getting to an emergency room? Another important reason to protect against the further demise of rural hospitals is the fact that hospitals attract physicians to a particular geographic area. Without a hospital, physicians may not want to practice in that particular area. This would have an even wider, more detrimental effect on beneficiaries' access to health care.

RECOMMENDATIONS

The National Committee has previously recommended refining the PPS system by modifying DRG's by severity of illness. A severity of illness index would reduce the financial incentive for hospitals to reduce the quality of care and deny access for high cost patients.

The National Committee favors cost containment and other ways to make our health care system as efficient as possible so that we can get the most for our ever-increasing health care dollars. However, we believe it is a mistake to indiscriminately cut provider reimbursements, because it inevitably hurts the consumer. Congress needs to look at teaching versus non-teaching hospitals and rural versus urban hospitals to make sure one category of hospitals does not suffer unduly while another profit unfairly. The National Committee recommends that Congress approve the ProPAC recommendation to increase urban hospital rates by 3.8 percent and rural hospitals by 4.6 percent in fiscal year 1989.

○